Jurisdictional Statement

Office-Supreme Court, U.S.
FILED
JUL 31 1981

81-212

No.

In the Supreme Court of the United States

OCTOBER TERM, 1980

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

WILLIAM MCCLURE, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

JURISDICTIONAL STATEMENT

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QUESTION PRESENTED

Whether 42 U.S.C. 1395u(b)(3)(C), which provides that hearings on claims under Part B of the Medicare Act are to be conducted by private insurance carriers, violates the due process rights of medicare claimants because it does not provide for a hearing before an Administrative Law Judge in the Department of Health and Human Services who has no connection with the carrier that first denied the claim.

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JURISDICTIONAL STATEMENT

OPINION BELOW

The opinion of the district court (App. A, *infra*, 1a-19a) is reported at 503 F. Supp. 409.

JURISDICTION

Three named plaintiffs brought this class action challenging the constitutionality of the hearing procedures provided under Part B of the Medicare Act, 42

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* Blue Shield of California also was named as a defendant, along with the Secretary of HHS, in the district court. The named plaintiffs are William McClure, Charles Shields, and "Ann Doe", who represent a class of all beneficiaries of the Part B Medicare Program who have received a decision of a carrier hearing officer dated on or after May 1, 1980, in which a request for payment of benefits has been denied in whole or in part.

U.S.C. (& Supp. III) 1395j-1395w. The district court apparently determined that it had jurisdiction over the case under either 28 U.S.C. 1331 or 1361. See note 16, *infra*. The district court entered summary judgment for appellees on their due process claim on July 9, 1980, and on the same date ordered the Secretary to prepare a plan to implement the summary judgment. App. B, *infra*, 20a-23a. On April 9, 1981, following its rejection of the Secretary's proposed plan, the district court entered an order for implementation of the summary judgment order. App. C, *infra*, 24a-30a. On May 1, 1981, a notice of appeal from the district court's April 9 order was filed on behalf of the Secretary in the United States District Court for the Northern District of California (App. D, *infra*, 31a-33a). The final judgment of the district court declaring unconstitutional the hearing procedures prescribed by 42 U.S.C. 1395u(b)(3)(C) (App. E, *infra*, 34a-37a) was filed on May 1, 1981, and entered in the court's docket on May 5, 1981. The district court also filed an order on May 1, 1981 (App. F, *infra*, 38a-40a) denying the government's motion for reconsideration of the April 9, 1981 order and for a stay pending appeal. On May 5, 1981, a notice of appeal from the district court's final judgment was filed on behalf of the Secretary in the United States District Court for the Northern District of California. App. G, *infra*, 41a-43a. On June 26, 1981, Justice Rehnquist extended the time within which to docket the appeal to and including August 1, 1981. The jurisdiction of this Court is invoked under 28 U.S.C. 1252.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

1. The Fifth Amendment to the United States Constitution provides in pertinent part:

> No person shall * * * be deprived of life, liberty, or property, without due process of law * * *.

2. Section 1842(b)(3)(C) of the Social Security Act, 42 U.S.C. 1395u(b)(3)(C), provides:

> (3) Each such contract [between the Secretary of Health and Human Services and the carrier] shall provide that the carrier—
>
> * * * * *
>
> (C) will establish and maintain procedures pursuant to which an individual enrolled under [Part B] will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under [Part B] with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

STATEMENT

This case involves a challenge to the provisions for review of benefit determinations under Part B of Title XVIII of the Social Security Act, commonly known as the Medicare Act. Before stating the facts, we shall describe the Part B program and the hearing provisions that appellees challenge.

1.*a.* The Medicare Act is divided into two parts. Part A provides insurance for hospital and related post-hospital services. 42 U.S.C. (& Supp. III) 1395c to 1395i-2. Part B provides a voluntary program of supplementary medical insurance covering, in general, 80% of the reasonable costs of certain other services—primarily physicians' services and such items as medical supplies, x-rays, and laboratory tests. 42 U.S.C. (& Supp. III) 1395k, 1395*l*, and 1395x(s).

Benefits under Part B are paid out of the Federal Supplementary Medical Insurance Trust Fund established in the Treasury. 42 U.S.C. 1395a and (& Supp. III) 1395g. The Supplementary Trust Fund is sup-

ported by appropriations from the Treasury and by premiums paid by those persons who are 65 or older or disabled and who choose to enroll in the Part B program. 42 U.S.C. (& Supp. III) 1395c, 1395i, and 1395w; see *Mathews* v. *Diaz*, 426 U.S. 67, 70 n.1 (1976).

The Secretary of Health and Human Services (HHS) is responsible for determining whether an individual is eligible to enroll and has enrolled in the Part B program. 42 U.S.C. 1395ff(a). If the beneficiary is dissatisfied with the Secretary's determination regarding his eligibility for or enrollment under Part B, he is entitled to an administrative hearing by the Secretary and to judicial review of the Secretary's final decision after the hearing. 42 U.S.C. 1395ff(b)(1)(B).[1]

The day-to-day administration of the Part B Medicare program requires the determination of a vast number of individual claims for reimbursement submitted by or on behalf of persons who are enrolled under Part B. In 1978 alone, more than 124 million such claims were processed. App. A, *infra*, 14a. When it enacted the Medicare Act in 1965, Congress concluded that a reimbursement program of this dimension and complexity could be administered most efficiently by private insurance carriers, which, in conducting their private insurance business, had acquired considerable experience in determining whether physicians' and other services are medically necessary and in calculating the reasonable charge for the services in the particular locality. S. Rep. No. 404 (Pt. 1), 89th Cong., 1st Sess., 53-54 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 46 (1965); see also 42 U.S.C. 1395u(a); 42 C.F.R. 405.670 (1979). Accordingly, Congress authorized the Secretary of HHS to enter into contracts with private insurance carriers under which the carriers would determine and pay

[1] The administrative hearing and judicial review are available as provided in 42 U.S.C. 405(b) and (g), which govern hearings and judicial review under Title II of the Social Security Act (Old Age, Survivors, and Disability Insurance Benefits).

Part B benefits on behalf of the Secretary. 42 U.S.C. 1395u(a). Pursuant to these contracts, the carriers receive advances of funds (42 U.S.C. 1395u(c)), which they then disburse to claimants in reimbursement for medical services found by the carriers to be covered by Part B. *Ibid.*; 42 U.S.C. 1395u(a)(1)(A), 1395u(b)(3)(A) and (B), 1395u(c). The contracts also provide for the federal government to pay the carriers' necessary and proper costs of administering the program. 42 U.S.C. 1395u(c).

b. Claims for payment under Part B are submitted directly to the insurance carrier that is responsible for administering the Part B program in a particular geographical area. The claim may be submitted either by the beneficiary or by the physician or other person who furnished the services if the beneficiary has assigned his reimbursement claim to that person. 42 U.S.C. 1395u(b)(3)(B); 42 C.F.R. 405.801(a), 405.802(b).[2]

The Secretary has promulgated detailed regulations that the carriers must follow in considering requests for payment under Part B. See 42 C.F.R. Part 405, Subpart H. When a claim is submitted, the carrier must make an initial determination whether the services for which payment is sought were reasonable and necessary for the diagnosis or treatment of an illness and are otherwise covered by Part B and, if so, whether the charge for the services is reasonable. 42 C.F.R. 405.803(b); see 42 U.S.C. 1395u(a)(1)(A), (& Supp. III) 1395u(b)(3) and 1395y(a). The carrier must mail a written notice of this determination to the claimant, informing him of his right to have the initial determination reviewed if he is dissatisfied with it. 42 C.F.R. 405.804. If the claimant does not request a review, the initial determination by the carrier is final and binding upon the claimant. 42 C.F.R. 405.806.

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[2] The assignee of a claim has the same procedural rights as the beneficiary from whom he has accepted an assignment. 42 C.F.R. 405.801(a).

If the claimant requests a review of the initial determination, he must be given a reasonable opportunity to submit written evidence and contentions of fact or law. 42 C.F.R. 405.809. Review of the claim then is made upon the basis of the evidence in the record (42 C.F.R. 405.810) by an employee of the carrier other than the employee who made the initial determination. App. A, *infra*, 3a. The carrier must send the claimant a written notice of the review determination, including a statement of the basis for the determination. The carrier must also advise the claimant of his statutory right under 42 U.S.C. 1395u(b)(3)(C) to an evidentiary hearing conducted by the carrier if the amount remaining in controversy is $100 or more. 42 C.F.R. 405.811. If the claimant does not request an evidentiary hearing, the review determination is final and binding upon the claimant. 42 C.F.R. 405.812.

The hearing is conducted by a hearing officer, designated by the appropriate official of the carrier (42 C.F.R. 405.823), who has not participated personally at any prior stage of the case. 42 C.F.R. 405.824; App. A, *infra*, 9a. The hearing officer is directed to "inquire fully into the matters at issue," and the claimant is entitled to submit additional documents, examine witnesses (or request the hearing officer to examine witnesses), and present argument. 42 C.F.R. 405.830. The hearing officer's decision must be based on the record of the hearing and must be supported by findings of fact and a statement of reasons. 42 C.F.R. 405.834. The decision by the carrier's hearing officer is final and binding upon the parties (42 C.F.R. 405.835), and there is no right under the Act to an administrative hearing by the Secretary or judicial review of that decision. See 42 U.S.C. 405(h) and 1395ii; compare 42 U.S.C. 1395ff(b)(1)(C).

2. The instant case is a nationwide class action brought in the United States District Court for the Northern District of California challenging the Medicare Part B hearing procedures. The district court certified a class of all persons who have received decisions from carrier

hearing officers dated on or after May 1, 1980, in which a claim for reimbursement under Part B of the Medicare Act was denied in whole or in part. App. E, *infra*, 35a.

On cross motions for summary judgment (App. B, *infra*, 20a), the court held that the current system of Part B hearings conducted by the carriers, as prescribed in 42 U.S.C. 1395u(b)(3)(C), violates the Due Process Clause of the Fifth Amendment. The district court therefore held that Part B beneficiaries are entitled to have final determinations with respect to their claims made by Administartive Law Judges in HHS, who are independent of the insurance carriers with which the Secretary has contracted for the administration of the Part B program. App. E, *infra*, 35a-36a; see also App. A, *infra*, 8a-16a, 18a-19a; App. B, *infra*, 21a. The court relied on two different lines of reasoning.

a. First, the district court concluded (App. A, *infra*, 9a-11a) that the requirement in 42 U.S.C. 1395u(b)(3)(C) that hearings be conducted by a hearing officer appointed by the carrier violates the Due Process Clause because, in the court's view, the hearing officer is not impartial. The court acknowledged (App. A, *infra*, 9a) that the hearing officer does not participate personally in the case prior to the hearing. Nevertheless, the court concluded (*ibid.*) that the officer has been "vicariously involved" in the case because he was appointed by the carrier, which has twice denied the claim that is the subject of the hearing. This, the court concluded, "poses a constitutionally-unacceptable risk of decisions tainted by bias" (*id.* at 10a), because the hearing officers might be reluctant to overturn the previous determinations by the carrier.

The court found this risk of bias "heightened" by what it perceived to be the hearing officers' "pecuniary interest in currying the carrier's favor" (App. A, *infra*, 10a) by denying the claim. The court acknowledged (*ibid.*) that the expense of the hearing officer's salary is borne not by the carrier, but by the federal government as part of the carrier's overall reimbursable cost of administering

the Part B program. Nevertheless, the court concluded (*ibid.*) that the hearing officer has a pecuniary interest in a Part B determination because he is dependent upon the carrier's decision regarding whether, and how often, to call upon his services.

b. In addition to finding that hearings conducted by hearing officers appointed by the carriers pose a risk of bias, the district court concluded (App. A, *infra*, 12a-16a) that appellees are constitutionally entitled to a hearing before an ALJ in HHS because, in the court's view, such a hearing would be more reliable than one conducted by a carrier. In reaching this conclusion, the court considered the three factors set forth in this Court's opinion in *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976).

First, in weighing the private interest at stake, the court acknowledged (App. A, *infra*, 13a) that the right to receive reimbursement under Part B of the Medicare Act for particular medical services is less substantial than the right to receive welfare or social security benefits[3] because Medicare benefits are not based on financial need, because Part B covers only supplementary rather than primary medical services, and because the denial of a particular claim does not render the beneficiary ineligible to participate in Medicare generally and thereby deprive him of the right to receive reimbursement for other services. The district court nonetheless concluded (*id.* at 13a) that a denial of reimbursement for particular services could cause considerable hardship to the individual.

Second, the court found the record "inconclusive" (App. A, *infra*, 13a) on whether the provision in 42 U.S.C. 1395u(b)(3)(C) for hearings to be conducted by carrier hearing officers poses a high risk of an erroneous deprivation of Medicare benefits. The court acknowledged

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[3] Welfare and social security benefits were at issue in *Goldberg* v. *Kelly*, 397 U.S. 254 (1970), and *Califano* v. *Yamasaki*, 442 U.S. 682 (1979), cited by the district court (App. A, *infra*, 13a).

(*ibid.*) the Secretary's statistics showing that, in conducting review determinations, carriers wholly or partially reversed their initial determinations in more than 50% of the cases considered. The court also acknowledged (*ibid.*) the statistics showing that carrier hearing officers reversed prior decisions, in whole or in part, in more than 40% of the cases brought before them following the carrier's review determination. But the court declined to rely on these data as demonstrating that carriers and their hearing officers give close scrutiny to individual claims in the review process because the figures did not show how many of the reversals were partial rather than total or how many were "technical" rather than "substantive" reversals. *Ibid.* The court also declined to rely on the statistics because of what it perceived to be insufficiencies in the hearing officers' training and eligibility criteria, such as the absence of any requirement that hearing officers have a law degree. The court therefore "assumed that additional safeguards [*i.e.*, ALJ hearings in HHS] would reduce the risk of erroneous deprivation of Part B benefits" (*id.* at 13a-14a).

Third, although it recognized that "[t]he government clearly has a strong interest in controlling the costs associated with the Part B Medicare program" (App. A, *infra*, 14a) and that more than 124 million Part B claims were processed in 1978 (*ibid.*), the court concluded that a second round of evidentiary hearings conducted by ALJs in HHS after a carrier hearing officer has denied a claim would not be unduly costly (App. A, *infra*, 14a). The court did not, however, attempt to determine the incremental cost or burden to HHS of conducting ALJ hearings.[4]

[4] The court rejected appellee's argument that the Due Process Clause requires the use of a preponderance of the evidence, rather than substantial evidence, standard in Part B hearings and that great weight should be attached to medical evidence (App. A, *infra*, 16a-17a). The court also concluded that the difference in procedures available in reviewing claims for benefits under Part A and Part B of the Medicare Act does not violate the equal protection guarantee of the Due Process Clause of the Fifth Amendment (*id.* at 17a-18a).

c. The district court's final judgment, entered on May 1, 1981, required the Secretary to take all necessary action to ensure that persons whose Part B claims were denied in whole or in part by a carrier's hearing officer between May 1, 1980, and April 30, 1981, were notified by July 8, 1981, of their right to an administrative appeal in the form of a de novo hearing before an ALJ in HHS if the amount remaining in controversy after the carrier hearing is at least $100. App. E, *infra*, 36a-37a. For hearing officer decisions rendered after April 30, 1981, the court's judgment required the Secretary to take all necessary action immediately to ensure that a notice of the right to an ALJ hearing was sent to the claimant along with the hearing officer's decision. *Ibid.*[5] However, on June 12, 1981, Justice Rehnquist issued an order staying the district court's order of April 9, 1981 and its final judgment of May 1, 1981, pending the timely docketing of the appeal and the Court's disposition of the appeal. Apps. H and I, *infra*, 44a-48a.[6]

THE QUESTION IS SUBSTANTIAL

The district court has held unconstitutional the hearing procedures established by Congress to resolve claims arising under one of the largest federal benefit programs. When Congress passed the Medicare Act in 1965, it concluded that the supplementary insurance program under Part B of the Act could be administered most efficiently by private insurance carriers, which already were ex-

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[5] The district court declined to accept an alternative plan developed by the Secretary to implement the district court's summary judgment order that hearing officers must be independent of the carriers. Under the Secretary's plan, submitted to the district court in the form of an affidavit of Daniel L. Skoler, Deputy Associate Commissioner of the Social Security Administration, hearings would have been conducted by attorney-advisors in the Social Security Administration's Office of Hearing and Appeals, rather than by ALJs.

[6] The district court previously had denied the government's motion for a stay pending appeal. App. F, *infra*, 38a-40a.

perienced in deciding whether physicians' and other services are medically necessary and in calculating the reasonable charge for those services. See page 4, *supra*, Consistent with this judgment, Congress determined that evidentiary hearings on disputed Part B claims should be conducted by the expert carriers in whom it had entrusted other aspects of the day-to-day administration of the Part B Medicare program. Congress also concluded that further review of carrier decisions, after completion of the statutorily required "fair hearing," was not warranted, especially in view of the relatively small amount of money involved in the typical Part B claim.[7]

The decision of the court below disregards this considered judgment of Congress and requires the Secretary to conduct a *second* evidentiary hearing on a claim after the carrier has conducted the statutorily required "fair hearing" on the same claim and denied it. Only the most convincing demonstration of the inadequacy of the three-step review process established by Congress and the Secretary could support such a holding and the duplicative hearings by ALJs in HHS ordered by the district court in this case. Yet the district court held 42 U.S.C. 1395u(b)(3)(C) unconstitutional solely on the basis of unfounded speculation that carrier hearing officers may be biased and that ALJ hearings in HHS might reduce the risk of erroneous decisions. The decision below therefore requires review by this Court.

1. The district court concluded that the Due Process Clause does not permit the final determination of a claim under Part B of the Medicare Act to be made by

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[7] See, *e.g.*, S. Rep. No. 404, *supra*, at 54-55; see also H.R. Conf. Rep. No. 92-1605, 92d Cong., 2d Sess. 61 (1972); 118 Cong. Rec. 33992 (1972) (remarks of Sen. Bennett). Congress' decision to foreclose any right of appeal to the Secretary or judicial review of benefit determinations under Part B is explained more fully in our brief in *United States* v. *Erika, Inc.*, No. 80-1594, at 20-38. We are furnishing appellees with a copy of the brief for the United States in *Erika*.

a hearing officer designated by the carrier because the hearing officer's impartiality is compromised by (a) the prior involvement of employees of the carrier in the case and (b) what the court perceived to be the hearing officer's own pecuniary interest in its outcome.

a. The district court acknowledged (App. A, *infra*, 9a, citing 42 C.F.R. 405.824) that carrier hearing officers do not participate at any stage of the pre-hearing consideration and review of the claims they consider, thereby eliminating any risk that a hearing officer personally might have prejudged the merits of a particular claim. Compare *Gibson* v. *Berryhill*, 411 U.S. 564, 578-579 (1973). The court concluded, however, that a hearing officer has been "vicariously involved" in reviewing the claim he considers because the officer is designated by a carrier that has twice denied that claim. App. A, *infra*, 9a. As a result, the court reasoned (*ibid.*), the hearing officer might be reluctant to disagree with the initial determination and subsequent file review of the claim made by the carrier. This conclusion is incorrect.

As this Court has made clear, there is "a presumption of honesty and integrity in those serving as adjudicators." *Withrow* v. *Larkin*, 421 U.S. 35, 47 (1975). The burden of overcoming this presumption is a "difficult" one, requiring a convincing showing that, "under a realistic appraisal of psychological tendencies and human weakness," the particular adjudicatory procedure "poses such a risk of actual bias or prejudgment that the practice must be forbidden if the guarantee of due process is to be adequately implemented." *Ibid.*

In *Withrow* v. *Larkin*, *supra*, the Court applied this principle in rejecting an accusation that members of a body responsible for adjudicating a matter were biased because of their *own* prior involvement in the matter in the course of investigation and issuance of a complaint. See also *FTC* v. *Cement Institute*, 333 U.S. 638, 700-703 (1948); *NLRB* v. *Donnelly Garment Co.*, 330 U.S. 219,

236-237 (1947). The presumption of honesty and integrity must be even stronger—and the resulting burden on the person alleging bias even heavier—where, as here, the adjudicator has had no prior personal involvement whatever in the particular matter. Yet the district court's opinion in the instant case offers nothing (other than a bare assertion) to support its suggestion that a carrier hearing officer charged with objectively reviewing evidence received at a de novo hearing and issuing a reasoned decision on the basis of that evidence will ignore his responsibility merely because an employee of the carrier that appointed him previously had reviewed the claim and denied it.[8]

In many cases, the initial and subsequent review determinations by the carrier will have been based on a less complete record than that developed by the hearing officer. Thus, if the hearing officer reverses a prior determination in whole or in part, he does not necessarily thereby admit error in the carrier's previous determination. Instead, "[his] position most probably would

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[8] In concluding that hearing officers should not review determinations made by other persons affiliated with the carrier, the district court relied (App. A, *infra*, 10a) in part on the practice of judges who disqualify themselves in matters handled by their former law firms during the period of their association with the firms. However, members of a law firm, as advocates, generally have a shared financial and professional stake in the outcome of a case. A judge's impartiality in a case therefore might reasonably be questioned if he previously was associated with a law firm that was an *advocate* for one party to the case. But a carrier under Part B of the Medicare Act, unlike a law firm, "operates essentially, and is intended so to do, as an adjudicator and not as an advocate or adversary" (*Richardson* v. *Perales*, 402 U.S. 389, 403 (1971)), and the hearing officer designated by the carrier therefore acts as "an examiner charged with developing the facts" and does "not act as counsel." *Id.* at 410. Accordingly, the hearing officer and the other employees of the carrier responsible for reviewing a claim have no pecuniary or professional interest in favoring or opposing that claim on the merits. For these reasons, the standards of conduct applicable to a judge who previously was a member of a law firm that appeared in a case have no application in this context.

merely reflect the benefit of a more complete view of the evidence afforded by an adversary hearing." *Withrow* v. *Larkin*, *supra*, 421 U.S. at 57-58. Moreover, even if a hearing officer's decision in favor of a claimant in some cases may be viewed as an admission of error in the carrier's prior decision on the claim, the hearing officer, his superiors, and the carrier employees are most unlikely to view such a decision on one of the numerous claims for reimbursement submitted to the carrier to be of sufficient moment to deter the hearing officer from reaching the correct result. For these reasons, "under a realistic appraisal of psychological tendencies and human weakness" (*id.* at 47), the district court plainly erred in finding a reasonable likelihood of bias resulting from the prior involvement of other persons affiliated with the carrier.

Moreover, a finding of an institutional or "imputed" bias based solely on the adjudicator's affiliation with an institution in which the matter previously has been considered might call into question the constitutionality of administrative appeal procedures within a government agency. Viewed in this manner, the due process holding of the district court concerning institutional bias " 'assumes too much and would bring down too many procedures designed, and working well, for a governmental structure of great and growing complexity.' " *Withrow* v. *Larkin*, *supra*, 421 U.S. at 50, quoting *Richardson* v. *Perales*, 402 U.S. 389, 410 (1971).

And, significantly, the record in this case wholly fails to substantiate the suggestion of bias in the carrier appeal procedures. As the district court acknowledged (App. A, *infra*, 13a), the record shows that in review determinations conducted between 1975 and 1978, carriers wholly or partially reversed their initial determinations in between 51% and 57% of all cases. Of the adverse review determinations subsequently brought before hearing officers during this same period, the review determination was reversed, in whole or in part,

in between 42% and 51% of the cases. *Ibid.* These data obviously do not reflect a reluctance to disagree with previous decisions of the carrier; to the contrary, they "attest[] to the fairness of the [carrier review] system and refute[] the implication of impropriety." *Richardson* v. *Perales*, *supra*, 402 U.S. at 410.

b. The district court concluded that the risk of possible bias resulting from the carrier's previous denial of a claim was "heightened" by what the court believed to be the hearing officer's pecuniary interest in the outcome of the hearing. This suggestion of bias is wholly without merit as well.

Any claim found by the hearing officer to be meritorious is paid by the federal government, as are the salary or fee of the hearing officer and the carrier's other expenses of administering the Part B program. 42 U.S.C. 1395u(c). Thus, neither the hearing officer's own income nor the income of the entity with which he is affiliated—the carrier—is affected in any way by the outcome of the hearing. Compare *Tumey* v. *Ohio*, 273 U.S. 510 (1927); *Ward* v. *Village of Monroeville*, 409 U.S. 57 (1972); see also *Marshall* v. *Jerrico, Inc.*, 446 U.S. 238, 250-251 (1980).

The district court acknowledged (App. A, *infra*, 10a) that the hearing officer's salary is unaffected by the decision he reaches, but it nevertheless concluded that the hearing officer has a pecuniary interest in currying the carrier's favor by denying otherwise meritorious claims.[9] However, because a claim found by the carrier

[9] Some hearing officers are not full-time employees of the carriers, but are instead retired employees or ALJs, outside lawyers, or other persons who are appointed by carriers as needed. The court reasoned (App. A, *infra*, 10a) that the carrier's ability to refuse to call upon a particuar hearing officer in future cases might lead the officer to deny the claim pending before him. But the court cited no evidence that a carrier has ever ceased to call on a particular hearing officer's services because he ruled in favor of a claimant, and, in any event, there is no reason to believe that the carrier would encourage hearing officers to deny valid claims. See pages 15-16, *infra*.

and to make these payments. 42 U.S.C. 1395u(a)(1)(A)

to be meritorious is paid by the federal government, not the carrier, the *carrier* has no pecuniary interest in denying a claim. Accordingly, there is no basis for the district court's assumption that the *hearing officer* could effectively curry favor with the carrier—and therefore have a pecuniary interest in the outcome—by rendering a decision against the claimant. To the contrary, the carrier's contract with the Secretary obligates the carrier to make determinations of the amount of payments required to be made under the Act for covered services and (B), (& Supp. III) 1395u(b)(3); 42 C.F.R. 421.200; see also 42 C.F.R. 405.803(a) and (b). The Secretary may terminate the contract at any time, after notice and opportunity for a hearing, if he finds that the carrier has failed substantially to carry out the contract or is doing so in a manner inconsistent with the efficient and effective administration of the Part B program. 42 U.S.C. 1395u(b)(4); 42 C.F.R. 421.205(a). In order to ensure compliance with the contract and thereby avoid possible termination, it would be in the carrier's interest—and therefore presumably also in the interest of a hearing officer seeking to maintain the favor of the carrier—to ensure that claims are paid when the Act and implementing regulations so require and are disallowed when they do not.

A carrier's compliance is measured, moreover, by looking to its overall performance under the contract, of which decisions by carrier hearing officers are a relatively minor part. Under these circumstances, any possibility that a decision by a particular hearing officer might itself be the cause of a contract termination—and that carriers therefore might pressure hearing officers to skew the results of their hearings in order to avoid the consequence of termination—is " 'so remote, trifling and insignificant that it may fairly be supposed to be incapable of affecting the judgment of or of influencing the conduct of an individual.' " *Tumey* v. *Ohio*,

supra, 273 U.S. at 531; cf. *Marshall* v. *Jerrico, Inc.*, *supra*, 446 U.S. at 251-252.[10]

2. The district court also erred in concluding that carrier hearings are inadequate under the Due Process Clause, even apart from the possibility that carrier hearing officers may be biased. The Act and implementing regulations establish a three-stage process for review of claims by the carrier, consisting of an initial determination of the reimbursement claim as submitted, an independent record review of the claim by a different employee of the carrier, and an evidentiary hearing before a third person designated by the carrier. These measures provide ample procedural protection for Part B claimants. There is no basis for the district court's holding that yet another layer of review, and a *second* evidentiary hearing on the same claim, must be provided by the Secretary.

"The guarantees of due process call for a 'hearing appropriate to the nature of the case.'" *United States* v. *Raddatz*, 447 U.S. 667, 677 (1980), quoting *Mullane* v.

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[10] This Court has rejected due process challenges on grounds of personal bias where there was a far more direct nexus than has been alleged in this case between the conduct of the official whose partiality was challenged and the financial consequences for that official or the entity with which he was affiliated. See *Bevan* v. *Krieger*, 289 U.S. 459 (1933); *Dugan* v. *Ohio*, 277 U.S. 61 (1928).

The district court also concluded (App. A, *infra*, 11a) that the absence of specific criteria established by the Secretary for the selection of hearing officers and the fact that training of hearing officers is conducted by the carriers, not HHS, constitute other "indicia" of potential bias. Contrary to the district court's view, however, these factors merely reflect the deference Congress and the Secretary have shown to the experienced private insurance carriers in determining how to administer the Part B program most effectively. Moreover, because the statute creates no institutional incentive for carriers to be biased against claimants, there is no reason to believe that the Secretary's entrusting of the selection and any necessary formal training of hearing officers to the carriers has introduced bias into the hearing process.

Central Hanover Bank & Trust Co., 339 U.S. 306, 313 (1950). Because Congress concluded that private insurance carriers, rather than a government agency, could most efficiently pay claims and otherwise administer the Part B insurance program on a day-to-day basis, it was reasonable for Congress to conclude that an evidentiary hearing conducted by a representative of the responsible carrier, rather than by a government official, would be the type of "hearing appropriate to the nature of the case" under Part B. This congressional judgment is fully consistent with the Due Process Clause.

In *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976), the Court held that identification of the dictates of due process in any given situation requires consideration of three distinct factors:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

See also *Little* v. *Streater*, No. 79-6779 (June 1, 1981), slip op. 4; *Lassiter* v. *Department of Social Services*, No. 79-6423 (June 1, 1981), slip op. 8; *United States* v. *Raddatz*, *supra*, 447 U.S. at 677. The district court seriously misapplied this test here.

a. First, the private interest at stake is the claimant's interest in receiving the requested level of reimbursement, typically relatively small in amount, for the services that gave rise to the particular claim. The carrier's decision on this discrete issue does not affect the beneficiary's ability to participate in the Medicare program generally and receive benefits under it in other circumstances. When such broader questions of an individual's *eligibility* to enroll under the Part B program are raised, the Act

does provide a right to an administrative hearing by the Secretary. 42 U.S.C. 1395ff(b)(1)(B); see also *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773, 786-787 (1980).[11] In addition, as the district court acknowledged (App. A, *infra*, 13a), Medicare benefits are not paid on the basis of financial need, and a denial of benefits therefore cannot be presumed to cause a grievous deprivation in the generality of cases. See *Mathews* v. *Eldridge*, *supra*, 424 U.S. at 340-341.

b. Second, in considering the risk of erroneous deprivation, the question is not whether an evidentiary hearing is required. Rather, the issue is whether the evidentiary hearing that concededly is required by statute and implementing regulations is constitutionally inadequate solely because of the identity of the person presiding at the hearing. The district court found the record "inconclusive" (App. A, *infra*, 13a) on whether existing carrier review procedures pose a high risk of erroneous deprivation of benefits. Contrary to the district court's view, however, the record is not inconclusive in this regard. The statistics showing a partial or total reversal in more than 40% of the cases in which a carrier hearing is held (see pages 8-9, *supra*) establish that hearing officers give close scrutiny to the claims. But even if the record were "inconclusive" regarding the risk of error under existing procedures, that would not furnish a basis for holding unconstitutional the hearing procedures established by an Act of Congress, in light of the substantial weight that must be given to the congressional judgment regarding the process that is due. Cf. *Mathews* v. *Eldridge*, *supra*, 424 U.S. at 349; *Vance* v. *Bradley*, 440 U.S. 93, 110-111 (1979).

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[11] Whether an individual satisfies the statutory criteria for eligibility to participate in the Medicare program raises questions uniquely within the competence of the Secretary, who must make related eligibility determinations under Title II of the Social Security Act. See 42 U.S.C. 402. Congress therefore concluded that the "'hearing appropriate to the nature of the case'" (*United States* v. *Raddatz*, *supra*, 447 U.S. at 677) when eligibility is at issue is a hearing conducted by the Secretary.

Moreover, the district court merely "assumed," without extended analysis, that administrative hearings conducted by ALJs in HHS would reduce the risk of an erroneous deprivation of Part B benefits. App. A, *infra*, 13a-14a. The court based this assumption solely on the fact that hearing officers do not receive extensive training by HHS and are not required to satisfy any threshold eligibility criteria, such as having a law degree. *Ibid.* However, this Court has made clear that the Due Process Clause does not require that the person presiding at an administrative hearing be a lawyer. See, *e.g.*, *Parham* v. *J.R.*, 442 U.S. 584, 607 (1979); *Morrissey* v. *Brewer*, 408 U.S. 471, 486, 489 (1972). A carrier reasonably could conclude, therefore, that a medical background or past experience in reviewing medical claims is as appropriate a qualification as a law degree for a hearing officer who often must review medical evidence in ruling on Part B claims. See *Parham* v. *J.R.*, *supra*, 442 U.S. at 607. In addition, the fact that HHS does not offer regular classroom training to carrier hearing officers [12] proves little in this case, given the absence of a finding that the qualifications of hearing officers are constitutionally inadequate.[13] But even if the district court had found that carrier hearing officers are insufficiently qualified to satisfy whatever standards the Due Process Clause might require, the appropriate solution would have

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[12] HHS does furnish hearing officers with a detailed manual for the conduct of hearings. See Attachment A to Exhibit A to the Defendants' Motion For Summary Judgment in the District Court.

[13] No such finding could be made on the record in this case, which pertains to Blue Shield of California. Of the six hearing officers of Blue Shield of California for whom background information was available, five had an extensive background in medicine or medical insurance and the sixth was a retired ALJ in the Social Security Administration. No information was available on the seventh hearing officer employed by Blue Shield. See Answer to Interrogatory No. 3 of Plaintiffs' Interrogatories to Blue Shield of California.

been to require that carrier hearing officers meet certain standards, not to strike down the statutory scheme.

c. Third, the substantial cost to the government and to the Medicare program of providing de novo ALJ hearings to duplicate the carrier hearings cannot be denied.[14] There are many millions of participants in the Medicare program, and more than 124 million Part B claims were filed in 1978 (App. A, *infra*, 14a). Even if only a fraction of those claims would eventually be appealed to an ALJ under the district court's order, the order nevertheless could add thousands of cases each year to the already overburdened docket of the ALJs in the Social Security Administration.[15] Such a result also would delay the final resolution of Part B claims and undermine Congress' considered decision to entrust administration of the Part B program to the carriers.

Thus, each of the factors in the three-part test announced in *Mathews* v. *Eldridge* weighs heavily against the district court's conclusion that the Due Process Clause

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[14] The district court indicated in its initial decision that the ALJ hearings could be *substituted for* the carrier hearings, thereby eliminating duplicative procedures. App. A, *infra*, 14a. However, the Medicare Act itself requires the carriers to provide a "fair hearing" whenever the amount in controversy is at least $100 (42 U.S.C. 1395u(b)(3)(C)), and the carriers therefore are not free to dispense with these hearings. In any event, HHS is not free, under the district court's final judgment, to dispense with the duplicative hearings. App. E, *infra*, 36a.

[15] Attachments to the affidavit of Stanley Katz in the district court indicate that more than 20,000 carrier Part B hearings are requested each year, and that this number is increasing. We have been informed by HHS that 26,171 carrier hearings were requested in calendar year 1980, and that claims were denied in whole or in part in 16,511 cases in that year. Although the residual amount in controversy after the carrier hearing may not exceed $100 in some cases—and therefore would not give rise to a right to a de novo ALJ hearing under the district court's order—a significant number of the 16,511 adverse carrier hearing officer decisions could be expected to be appealed to ALJs.

requires the Secretary to furnish an opportunity for ALJ hearings.[16]

CONCLUSION

Probable jurisdiction should be noted.

Respectfully submitted.

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JULY 1981

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[16] In the proceedings below, the government did not question the district court's jurisdiction to entertain appellees' constitutional challenge to the Medicare Act, and we do not challenge the district court's jurisdiction in this Court. Plaintiffs alleged that the district court had jurisdiction under 28 U.S.C. 1331 and 1361. Complaint ¶ 2. The district court determined that it had jurisdiction over the case, but without citation to the statutory provision upon which it relied. App. A, *infra*, 5a.

Congress has carefully restricted the availability of judicial review of claims arising under the Social Security Act to those situations in which that Act specifically provides for judicial review. 42 U.S.C. 405(h); *Weinberger* v. *Salfi*, 422 U.S. 749, 756-767 (1975). As we explain in our brief in *United States* v. *Erika, Inc.*, No. 80-1594, these same principles apply to judicial review of claims arising under the Medicare Act. See 42 U.S.C. 405(h), 1395ii and 1395ff.

At the same time, the Court has stated that it will not construe a statute to foreclose review of constitutional challenges to an Act of Congress unless Congress' intent to do so is manifested by "clear and convincing" evidence. *Johnson* v. *Robison*, 415 U.S. 361, 373 (1974); see also *Califano* v. *Sanders*, 430 U.S. 99, 109 (1977); *Weinberger* v. *Salfi*, *supra*, 422 U.S. at 762. See generally Rogers, *A Way Out of the Social Security Jurisdiction Tangle*, 21 Ariz. L. Rev. 689 (1979).

APPENDIX A

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

No. C-79-0201 WHO

WILLIAM MCCLURE, CHARLES SHIELDS, and "ANN DOE," individually and on behalf of a class of persons similarly situated, PLAINTIFFS

vs.

PATRICIA ROBERTS HARRIS, Secretary of the Department of Health, Education and Welfare, and BLUE SHIELD OF CALIFORNIA, DEFENDANTS

Filed May 19, 1980

OPINION

Three named plaintiffs bring this action on behalf of a class of Medicare beneficiaries challenging the constitutionality of the hearing procedures available under Part B of the Medicare program. 42 U.S.C. §§ 1395j-1395w, 1395ff. Defendants are Patricia Roberts Harris, Secretary of Health, Education and Welfare ("HEW"), and Blue Shield of California ("Blue Shield"), a private insurance carrier that administers Part B benefits under contract with HEW.

Plaintiffs claim that the statutory scheme, whereby the final determination of whether, or to what extent, Part B beneficiaries are entitled to claimed

benefits is made by hearing officers appointed by private insurance carriers, violates their rights to due process and equal protection of the law and unconstitutionally delegates judicial power to private parties.

Presently before the Court are plaintiffs' motion for class certification and both parties' cross-motions for summary judgment. For the reasons set forth below, the Court certifies this case as a class action, and grants in part and denies in part the parties' summary judgment motions.

I

The Medicare program, established in Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, provides health insurance benefits for aged and disabled persons. It consists of two subprograms. Part A covers certain costs of institutional care, such as hospital and nursing home fees. 42 U.S.C. §§ 1395c-1395i-2. Part B covers "supplementary" medical costs such as physicians' services and physical therapy. 42 U.S.C. §§ 1395j-1395w. The programs differ in the manner in which they are funded, the standards of eligibility, the scope of coverage, and the procedures for resolving claims disputes.

After incurring supplementary medical expenses, a Part B beneficiary submits a claim to the private insurance carrier with whom HEW has contracted to administer benefits in that beneficiary's locale.[1]

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[1] The Medicare statute authorizes the Secretary of HEW to enter into contracts with private insurance carriers to, among other things, determine the rates and amounts of payments under the "reasonable cost" and "reasonable charge" standards established by the statute, receive, disburse, and account for funds in the making of such payments, and conduct audits. 42 U.S.C. § 1395u(a).

The carrier makes an initial determination whether, and to what extent, the claimed benefits are covered. 42 C.F.R. §§ 405.803-405.806. Any claimant who is dissatisfied with the initial determination may request a "review determination," which involves a *de novo* review of the written record by a carrier employee different than the one who rendered the initial determination. 42 C.F.R. §§ 405.807-405.812. If the amount in controversy is at least $100, a claimant who is dissatisfied with the review determination may request an oral, evidentiary hearing. 42 U.S.C. § 1395u(b)(3)(C); 42 C.F.R. §§ 405.820-405.835. The hearing officer is appointed by the carrier and may be an employee of the carrier, but he may not hear "any case in which he is prejudiced or partial with respect to any party, or if he has any interest in the matter before him." 42 C.F.R. § 405.824. The hearing officer's decision is final; no further administrative or judicial review has been authorized by Congress or provided by HEW. 42 U.S.C. § 1395ff(b); 42 C.F.R. § 405.835.[2] Only where a dispute concerns a person's eligibility to enroll in the Part B program, rather than his entitlement to particular benefits claimed, may he appeal an adverse decision to the Secretary of HEW and, if the amount in controversy is at least $1,000, to the courts. 42 U.S.C. § 1395ff(b).

Each of the named plaintiffs submitted Part B claims to Blue Shield and was denied benefits, in whole or in part, by the carrier (upon both initial and review determinations) and then by carrier-

[2] The final decision of a hearing officer is subject to reconsideration and revision by the hearing officer, 42 C.F.R. § 405.841, but it is not appealable to the Secretary of HEW or the courts.

appointed hearing officers. Plaintiff William McClure was denied partial reimbursement for the cost of an air ambulance which transported him to a hospital specially equipped to treat his myocardial infarction. The hearing officer ruled that although air ambulance services were necessary, McClure could have been taken to a hospital that was closer to his home. Plaintiff Charles Shield was denied reimbursement for part of the cost of an operation that involved both a cholecystectomy and an appendectomy. The disallowed portion of his claim was that attributable to the appendectomy and was denied on the ground that the appendectomy was merely incidental to the cholecystectomy. Plaintiff Ann Doe [3] was denied reimbursement for the full cost of a sex-change operation on the ground that the operation was not medically necessary and therefore not covered by Medicare.[4]

Plaintiffs filed this action not to contest the substantive denial of their claims, but to challenge the procedures by which Part B claims disputes are resolved. They assert four constitutional claims. First, they argue that a hearing officer appointed by the same insurance carrier which has twice denied the claim under review (upon initial and review determinations) is not an impartial tribunal as required by the Due Process Clause of the Fifth Amendment. Second, they contend that the vesting of final decision-making authority in such hearing officers is an unconstitutional delegation of judicial power. Third, they

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[3] On January 11, 1980, at the hearing on the motions which are the subject of this Opinion, the Court granted plaintiff Ann Doe's motion to proceed by a fictitious name.

[4] Hospital costs related to the sex change operation were independently allowed under Part A.

claim that the procedures employed at Part B hearings do not comport with either the Due Process Clause or the Social Security Act because hearing officers are not guided by "fair evidentiary standards" such as the preponderance of the evidence rule. Fourth, plaintiffs allege that their right to equal protection of the law is violated insofar as the hearing procedures available under Part A are superior to those available under Part B of the Medicare program.

This Court has jurisdiction over the plaintiffs' constitutional claims because they are collateral to their substantive claims for Medicare benefits. *Mathews* v. *Eldridge*, 424 U.S. 319, 330 (1976). *See also Califano* v. *Sanders*, 430 U.S. 99, 109 (1977). As plaintiffs acknowledge, the Court lacks jurisdiction to review the merits of the decisions denying their benefits claims. 42 U.S.C. § 1395ff.

II

Plaintiffs seek to litigate these constitutional issues on behalf of a nationwide class of Part B beneficiaries whose claims for benefits have been or will be denied by carrier-appointed hearing officers. Defendants concede that plaintiffs satisfy the threshold requirements for maintaining a class action under Rule 23 of the Federal Rules of Civil Procedure. Nevertheless, they urge the Court to exercise its discretion to deny class certification or to restrict the scope of the proposed class.

The Court finds that the proposed class possesses each of the Rule 23(a) prerequisites to a class action. Even if limited, as defendants suggest, geographically to the Northern District of California and temporally to Part B beneficiaries who *will* be denied claimed benefits after hearing, the proposed class is

so numerous that joinder is impracticable, there are common questions of law involved, the named plaintiffs' claims are typical of other class members', and the named plaintiffs and their attorneys will fairly and adequately protect the interests of the class. In addition, the Court finds that a class action is properly maintainable under Rule 23(b)(2) because the defendants have uniformly applied the challenged statutory provisions and administrative policies to all class members and the declaratory and mandamus relief being sought would be appropriate with respect to the class as a whole.

Finally, the Court finds that it is not only permissible but also desirable that this action proceed on a class basis. Similar cases are currently pending in at least three other district courts. *Gadsden* v. *Califano*, No. C-75-2946 ALS (C.D. Cal., filed August 29, 1975); *Monroe* v. *Califano*, No. C-78-4175 ALS (C.D. Cal., filed Oct. 31, 1978) (consolidated with *Gadsden*); *Leduc* v. *Califano*, No. C-77-3386-S (D. Mass., filed Nov. 4, 1977); *Salitan* v. *Califano*, No. C-77-84D (M.D.N.C., filed Feb. 23, 1977). Another, similar case in a fourth district has already been decided. *Davis* v. *HEW*, 416 F.Supp. 448 (S.D.N.Y. 1976). A class action is the most efficient and expeditious means of reaching a final and binding resolution of the constitutional questions surrounding the Part B Medicare program. The class action device is particularly well suited to this situation, where the maintenance of countless individual actions might produce inconsistent demands upon defendants and inequitable results for similarly-situated plaintiffs. Although plaintiffs here would exclude from their proposed class all persons who are plaintiffs in the pending cases listed above, class certification would preclude any further proliferation of such lawsuits.

From this analysis flows the logical conclusion that the class should be nationwide in geographical scope. The statute and hearing procedures under attack apply to all Part B beneficiaries across the country. The antiproliferation aspect of class certification can be meaningfully realized only if the class is nationwide. Moreover, the Supreme Court recently underscored the appropriateness of nationwide classes in actions such as this. *Califano* v. *Yamasaki*, 442 U.S. 682, 701-703 (1979).

The appropriate temporal scope of the class is somewhat less obvious. Plaintiffs would include all persons who were denied Part B benefits by carrier-appointed hearing officers during the six years prior to the commencement of this suit, as well as all persons who will subsequently be denied Part B benefits after hearing. Defendants vigorously object to extending the class backward in time because a decision in plaintiffs' favor would disrupt settled results and impose substantial costs insofar as past hearings would have to be reopened. The Court finds that the burdens attendant upon resurrecting cases that were closed as long ago as 1973 far outweigh the benefits of doing so. In line with the approach adopted by the Supreme Court and other district courts in cases involving constitutional challenges to the Social Security Act and the Medicare program, the Court will certify a class comprised of persons who have been denied Part B benefits by carrier-appointed hearing officers within one year prior to the filing of this suit and subsequent thereto. *See Califano* v. *Yamasaki*, *supra*; *Wright* v. *Califano*, No. 77-4101-IH (C.D. Cal., Nov. 28, 1978) (order certifying class action) (Exhibit F attached to plaintiffs' memorandum in support of class certification; *Gray Panthers* v. *Califano*, No. 77-

488 (D.D.C., Nov. 22, 1977) (order certifying class action) (plaintiffs' Exhibit E), 466 F. Supp. 1317 (D.D.C. 1979) (summary judgment granted for defendant).

Accordingly, IT IS HEREBY ORDERED that plaintiffs' motion for class certification is GRANTED and that this action shall proceed as a class action under Rule 23(b)(2) of the Federal Rules of Civil Procedure. The class includes all beneficiaries of the Part B Medicare program who, within one year prior to the filing of this lawsuit and subsequent thereto, have been denied claimed benefits by carrier-appointed hearing officers. However, the class shall not include those persons who are named plaintiffs or members of a plaintiff class in any action pending against the Secretary of HEW which raises issues similar to those raised here.

III

Plaintiffs' strongest claim is that their due process rights are violated by the vesting of final, unreviewable decision-making power in hearing officers appointed by the insurance carrier. This argument, which is a frontal attack upon the statutory scheme, 42 U.S.C. §§ 1395u(b)(3)(C), 1395ff, is two pronged. First, plaintiffs contend that Part B hearing officers are not impartial tribunals in contravention of the Due Process Clause. Second, plaintiffs argue that the unavailability of any independent, administrative review of carrier-appointed hearing officers' decisions represents an unconstitutional delegation of judicial power. Each claim will be analyzed separately, but the Court notes at the outset that the two claims are closely interrelated. If hearing officers are potentially biased in favor of the carriers whose determinations they review, then the availability of an

independent, administrative appeal beyond the hearing officer level might well mitigate the harmful effects of such bias. On the other hand, if no independent tribunal is ever to review a hearing officer's decision, then impartiality must be fully ensured at the hearing-officer level.

A

It is well established that in order to satisfy the fair-hearing requirement of the Due Process Clause, a tribunal (whether administrative or judicial) must be impartial. *Withrow* v. *Larkin*, 421 U.S. 35, 46 (1975); *Gibson* v. *Berryhill*, 411 U.S. 564, 578-579 (1973); *Ward* v. *Village of Monroeville*, 409 U.S. 57 (1972). The adjudicator may neither have a pecuniary interest in the outcome nor have been the target of personal abuse or criticism from the party before him. *Withrow* v. *Larkin*, *supra*, 421 U.S. at 47.

With all due respect for the personal integrity of Part B hearing officers, this Court finds that their impartiality is compromised by virtue of both prior involvement and pecuniary interest. With respect to prior involvement, the Court notes that Part B hearing officers do not participate personally, prior to the hearing state, in any case which they adjudicate. 42 C.F.R. § 405.824. However, they have been vicariously involved because they are appointed by, and serve at the will of, the carrier which has not only participated in the prior stages of each case, but has twice denied the claims which are the subject of the hearing. Unlike situations where the standards governing an initial determination differ from those governing the subsequent outcome, Part B hearing officers could only rule in the beneficiaries' favor by directly overturning the carriers' decision. *Cf. Withrow* v. *Larkin*, *supra*, 421 U.S. at 57. The significance

of the hearing officers' prior involvement is underscored by the fact that five out of the seven hearing officers appointed by Blue Shield during the history of the Part B program are former *or current* Blue Shield employees.[5] That such prior involvement raises the specter of partiality has long been recognized by the Judicial Conference of the United States. Under Canon 3-C(1)(b) of the Code of Judicial Conduct, a judge should disqualify himself from adjudicating any case where "a lawyer with whom he previously practiced law served during such association as a lawyer concerning the matter." Heeding the admonition in Canon 3-C to avoid situations where their "impartiality might reasonably be questioned," many judges routinely disqualify themselves from hearing any matters in which their former law office is involved, whether or not the particular matter was pending before the judge left the firm. To apply appreciably more lax standards to hearing officers whose final decisions, unlike those of most judges, are appealable to no other tribunal, poses a constitutionally-unacceptable risk of decisions tainted by bias.

This risk is heightened by the fact that Part B hearing officers have a pecuniary interest in currying the carrier's favor. Although their salaries are paid from a federal fund and not by the carrier, their income as hearing officers are entirely dependent upon the carrier's decisions regarding whether, and how often, to call upon their services.

In *Davis* v. *HEW*, *supra*, the court stated that "[t]he mere fact that the hearing officer is employed

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[5] Blue Shield's answers to plaintiffs' interrogatories, No. 3, as summarized in plaintiffs' memorandum in support of summary judgment at 8, 10.

[by] the carrier does not render him constitutionally unacceptable." *Id.* 416 F.Supp. at 452. In this case, however, the record contains several indicia of potential bias beyond the "mere fact" that the carrier appoints the hearing officer. In addition to the factors summarized *supra*, the record indicates that there are no meaningful, specific selection criteria governing the appointment of hearing officers.[6] Apart from occasional training sessions presented by HEW, attendance at which is voluntary, hearing officers receive their only training from the carrier whose decisions they are called upon to review.[7] Whereas each one of these factors might not, by itself, contravene the constitutional requirement of impartiality, their combined effect is constitutionally impermissible.[8]

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[6] *See* Hearing Officers Handbook and Part B Carrier Manual for the extremely general selection criteria provided by HEW. Moreover, it bears note that HEW does not review actual selection decisions to determine whether even these minimal criteria are satisfied. Deposition of Jack C. Byrne, Appendix D to plaintiffs' memorandum in support of summary judgment, at 15-16.

[7] HEW's answers to interrogatories, No. 11 (in *Gadsden* v. *Califano*, No. C-75-2946 ALS (C.D. Cal., filed August 29, 1975), at 121-122; Byrne deposition, Appendix D, at 18-21.

[8] Although *Davis* v. *HEW*, 416 F.Supp. 448 (S.D.N.Y. 1976), is the only other decided case of which this Court is aware that addressed similar challenges to the Part B hearing process, several cases rejected partiality challenges to Provider Review Committees and analogous tribunals under Part A. *See, e.g., St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283, 292-293 (8th Cir. 1976), *cert. denied*, 429 U.S. 977 (1976); *Chelsea Community Hospital* v. *Michigan Blue Cross Ass'n*, 436 F.Supp. 1050, 1060-1061 (E.D. Mich. 1977); *Community Hospital of Indianapolis, Inc.* v. *Blue Cross Ass'n*, No. IP-73-C-615 (S.D. Ind. 1974) (De-

B

The second prong of plaintiffs' due process argument is that final decision-making authority may not be vested in carrier-appointed hearing officers. Plaintiffs claim that they are constitutionally entitled to a hearing before the Secretary of HEW either subsequent to or substituting for the hearing conducted by a carrier appointee. This claim must be analyzed under the balancing test set forth in *Mathews* v. *Eldridge, supra.* In determining what process is due in the circumstances present here, the Court is to consider three factors:

> "First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute

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fendants' Exhibit C). In those cases, the providers who were challenging the makeup of the hearing tribunal had voluntarily foregone the option of dealing directly with HEW, instead of with the carrier, and thereby entirely avoiding the carrier-appointed tribunal. Part B beneficiaries lack any such option.

In *Gray Panthers* v. *Califano,* 466 F.Supp. 1317, 1323 n.10 (D.D.C. 1979), the court summarily rejected a partiality challenge to carrier-appointed hearing officers. As in *Davis, supra* n.8, the *Gray Panthers* court apparently lacked the extensive factual record present here. Whereas the *Gray Panthers* footnote refers to but one potential source of bias, the record here establishes numerous such sources which, in combination, cast doubt upon the ability of Part B hearing officers to render final, unappealable decisions which both are, and appear to be, impartial.

procedural requirement would entail." *Id.*, 424 U.S. at 335.

The private interest at stake is the Medicare beneficiary's right to reimbursement for medical expenses covered by Part B of the Medicare program. Without slighting the importance of this right, the Court notes that it is not quite as precious as the right to receive welfare or social security benefits to which one is entitled. *Cf. Goldberg* v. *Kelly*, 397 U.S. 254 (1970); *Califano* v. *Yamasaki*, *supra*. Eligibility for Part B Medicare benefits is not based on financial need. Part B covers supplementary rather than primary services. Denial of a particular claim in a particular case does not deprive the claimant of reimbursement for other, covered, medical expenses. Nonetheless, it cannot be gainsaid that a Medicare beneficiary's right to reimbursement is sufficiently important to invoke the Due Process Clause, and that denial of that right may impose considerable hardship. *Cf. Gray Panthers* v. *Califano*, *supra*, 466 F.Supp. at 1320-1321.

Plaintiffs claim that the procedures currently used pose a high risk of erroneous deprivation of Medicare benefits. The record is inconclusive in this regard. Defendants establish that between 1975 and 1978, carriers wholly or partially reversed, upon "review determination," their initial determinations in 51-57 percent of the cases considered. Of the adverse determination decisions brought before hearing officers, 42-51 percent of the carriers' decisions were reversed in whole or in part.[9] However, defendants fail to indicate the extent or significance of the partial—as compared with total—reversals, or the breakdown between technical and substantive reversals. In light of plaintiffs' undisputed showing that carrier-ap-

[9] Affidavit of Stanley Katz, ¶ 9, and Attachment B thereto.

pointed hearing officers receive little or no formal training and are not required to satisfy any threshold criteria such as having a law degree,[10] it must be assumed that additional safeguards would reduce the risk of erroneous deprivation of Part B benefits.

The government clearly has a strong interest in controlling the costs associated with the Part B Medicare program. However, it is far from clear that the imposition of Part A hearing procedures would entail substantial additional costs. As defendants point out, more than 124 million Part B claims were processed by carriers in 1978.[11] Only a fraction of those claimants pursue their currently-available appeal remedies (*i.e.*, review determinations and hearings). If an appeal to the Secretary is made available, there is no indication that anything but an even smaller group of claimants will actually pursue this additional remedy. Moreover, the cost of providing such additional remedy will be minimized by the fact that the Secretary already maintains an appeal procedure, utilizing administrative law judges, for Part A claimants. To enable Part B claimants to appeal adverse hearing officers' decisions to Part A administrative law judges would not require the creation of a new appeals system or a new bureaucracy. It would simply increase the number of claimants who utilize the existing Part A administrative appeal. That would not be a cost-free change from the status quo, but neither should it be a costly one.

Taking into account the three governing factors, the Court concludes that the existing Part B hearing

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[10] Plaintiffs' memorandum in support of summary judgment at 6-13 and supporting documentation.

[11] Katz affidavit, ¶ 8.

procedure does not comport with due process. An important interest is at stake, there is a reasonable likelihood that additional procedures will reduce the risks of erroneous deprivation of benefits, and the costs of providing such procedures are not expected to be great.

This conclusion accords with much of the case law in this area. The only case involving the same challenges to the Part B program as those raised here did not reach the second prong of plaintiffs' due process argument. *Davis* v. *HEW*, *supra*, held that it does not offend the Constitution to delegate decision-making authority *to* carrier-appointed hearing officers; it did not resolve whether it is constitutional to deny an administrative appeal *from* the carrier-appointed decision maker. In *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283 (8th Cir. 1976), *cert. denied*, 429 U.S. 977 (1976), the Eighth Circuit addressed both issues. The Court found no unconstitutional bias, in the Part A context, in using carrier-appointed Provider Appeal Committees to resolve reimbursement disputes. *Id.*, at 292. However, the court also ruled that such committees may not make final, unreviewable determinations of law; the claimant must accept the committee's factual rulings but is entitled to appeal its legal interpretations of the statute and regulations to the Secretary. *Id.* at 292-293. Finally, in *Ass'n of American Physicians & Surgeons* v. *Weinberger*, 395 F.Supp. 125 (N.D. Ill. 1975), the court noted:

> "[I]t has been held permissible for agencies of the federal government to contract with private organizations in order to have such organizations perform governmental functions *as long as the particular administrative scheme provides for a*

> *hearing on the determination made by those private organizations.*" *Id.*, at 140 (emphasis added).

In the context of Part B reimbursement disputes, the risks of bias and of erroneous deprivation of benefits require the Secretary to make available an administrative review of carrier appointees' decisions. Only by vesting final decision-making authority in an independent tribunal will Part B beneficiaries' due process rights be adequately protected. At least two options are available to the Secretary. Existing Part B procedures might remain intact so long as aggrieved beneficiaries would be entitled to appeal carrier appointees' decisions to Part A administrative law judges. Alternatively, the separate Part B procedures might be terminated and Part B beneficiaries fully included within the existing Part A hearing process. Thus, the carriers' review determinations would be appealable directly to administrative law judges for ultimate resolution.

C

Plaintiffs also claim that Part B hearing procedures violate due process because the hearing officers are not bound by the preponderance of the evidence standard of proof and are not required to attribute particular weight to medical evidence. Under existing procedures, hearing officers are directed to base their decisions upon substantial evidence. Hearing Officers Handbook. Plaintiffs seek to require hearing officers to employ the preponderance of the evidence test, which would require a somewhat stronger showing by the prevailing party. However, plaintiffs neither cite decisional authority nor provide convincing argument sufficient to create a constitutional

violation out of the discrepancy between the substantial evidence and preponderance of the evidence tests. Neither do plaintiffs demonstrate that it is fundamentally unfair not to require hearing officers to ascribe great weight to medical evidence. Plaintiffs describe in considerable detail the cases presented at their hearings by each of the named plaintiffs and highlight the medical evidence which was necessarily rejected by the hearing officers in the course of denying or reducing their claims. However, the particular decisions are not reviewable by this Court and the administrative record lacks any indication that the absence of evidentiary standards regarding medical testimony deprived plaintiffs of due process.

D

Plaintiffs next argue that the inferior hearing procedures available to Part B beneficiaries as compared to those available to Part A beneficiaries deny them equal protection of the law. The salient differences between Part A and Part B hearings are: (1) Part A hearings are conducted by administrative law judges while carrier-appointed hearing officers conduct Part B hearings; and (2) Part A claimants may obtain judicial review of an administrative law judge's decision, where the amount in controversy exceeds $1,000, while there is no judicial review available under Part B.

Plaintiffs challenge primarily the first difference—the difference between an administrative law judge and a carrier appointee as a hearing officer. They claim that beneficiaries under both programs are similarly situated because all pay for their coverage (Part A beneficiaries pay through payroll deductions and Part B beneficiaries pay monthly premiums).

They also claim that an intermediate level of scrutiny should be applied here because medical care is a basic necessity. They contend that, under the intermediate test, the inferior Part B hearing procedures violate their equal protection rights.

Plaintiffs' argument rests upon two incorrect assumptions. First, beneficiaries under Parts A and B are not similarly situated. The programs have different eligibility requirements and different types of coverage. Some persons, such as plaintiff Ann Doe, participate in both programs. Second, intermediate scrutiny is inappropriate here. Although medical care is involved, the challenged discrimination is not between those receiving and those being denied medical care, or between those who can and those who cannot afford medical care, but rather between those covered for institutional care (Part A) and those covered for professional services (Part B). Instead, the rational basis test is applicable here. Plaintiffs have implicitly and correctly conceded that the differences between Part A and Part B hearing procedures are rationally based and free from invidious discrimination. *Cf. Gray Panthers, supra,* 466 F. Supp. at 1326; *Drs. Russi, Griffin & Snell, Ltd.* v. *Mathews,* 438 F.Supp. 1036, 1042-1044 (E.D. Va. 1977).

IV

The Court concludes that the Part B hearing procedures violate plaintiffs' due process rights insofar as the final, unappealable decision regarding claims disputes is made by carrier appointees whose impartiality is subject to doubt. However, the Part B hearing procedures do not violate plaintiffs' due process rights with respect to the evidentiary standards employed. Neither do the Part B procedures

violate plaintiffs' equal protection rights when compared to procedures available to Part A claimants. Accordingly,

IT IS HEREBY ORDERED that plaintiffs' motion for summary judgment is GRANTED with respect to the partiality and unappealability issues and DENIED with respect to the evidentiary standards and equal protection issues.

IT IS FURTHER ORDERED that defendants' motion for summary judgment is DENIED with respect to the partiality and unappealability issues and GRANTED with respect to the evidentiary standards and equal protection issues.

Plaintiffs shall prepare a form of judgment declaring that Part B beneficiaries are entitled to have a final determination of their claims made by a hearing officer independent of the carrier.

Dated: May 16, 1980.

/s/ William H. Orrick
WILLIAM H. ORRICK
United States District Judge

APPENDIX B

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

No. C-79-0201 WHO

WILLIAM MCCLURE, CHARLES SHIELDS, and "ANN DOE," individually and on behalf of a class of persons similarly situated, PLAINTIFFS

v.

PATRICIA ROBERTS HARRIS, Secretary of the Department of Health, Education and Welfare, and BLUE SHIELD OF CALIFORNIA, DEFENDANTS

Filed Jul. 9. 1981

SUMMARY JUDGMENT AND ORDER

This cause came before the Court on Friday, January 11, 1980, on cross-motions of the parties for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure, together with plaintiffs' motion for an order certifying a class action.

The Court having heard oral argument, and having considered the memoranda of points and authorities and other documents filed by the parties in support of and in opposition thereto; and the parties having agreed that there is no genuine issue as to any material fact so that the case is ripe for summary judgment; and,

The Court having held that a nationwide class should be certified consisting of all persons whose claims for Part B benefits have been denied by carrier-appointed hearing officers commencing one year prior to the filing of this lawsuit; and the Court having further held that the due process clause of the United States Constitution is violated by the Medicare Part B hearing system prescribed by 42 U.S.C. Section 1395u(b)(3)(c) and 1395ff, as more fully set forth in the opinion of the Court dated May 16, 1980, it is

ORDERED AS FOLLOWS:

1. Pursuant to Rule 23(b)(2) and 23(c)(1) of the Federal Rules of Civil Procedure, the present case is certified as a class action consisting of all persons who, on or after February 2, 1978, have had Medicare Part B hearings at which coverage of benefits has been wholly or partly denied, excluding persons who are plaintiffs in other actions currently pending against the Secretary of the Department of Health, Education and Welfare which raise issues similar to those raised herein.

2. Medicare Part B beneficiaries are entitled to have final determinations made with respect to their claims by hearing officers who are independent of the Medicare carriers. Therefore, the current system of Part B hearings provided by the carriers as prescribed by the Medicare Statute, 42 U.S.C. Section 1395u(b)(3)(c) and 1395ff, is declared to be in violation of the United States Constitution, and therefore void.

3. Defendant Patricia Roberts Harris, Secretary of the Department of Health, Education and Welfare,

shall prepare a plan to implement this judgment which covers the following matters:

a. The manner in which class members shall be informed of their rights to rehearings of their claims pursuant to this decision;

b. The system that defendant will establish to promptly provide new hearings with respect to the claims of the named and class plaintiffs that comply with the standards set forth by the Court in this decision;

c. The system that defendant will establish to provide future Part B hearings to all claimants that comply with the standards set forth by the Court in this decision; and

d. A timetable for effectuation of the plan.

4. The parties shall meet and discuss the form and content of an appropriate plan and submit a joint plan within 30 days from the date hereof. If the parties are unable to agree, Defendant HEW shall submit a proposed plan within 30 days from the date hereof, and plaintiffs shall file a written response to said proposed plan within 10 days thereafter. A hearing thereon shall be held on motion of either party, or by the court on its own motion.

5. Pending full implementation and approval of this plan, any future Medicare Part B hearing officer decision denying benefits in whole or in part with respect to claims of class members, shall include a clear and conspicious notice that the decision is not final, and that the person denied benefits has a right to request a new hearing conducted by a Social Security Administration Administrative Law Judge. Said notice shall specify name and address to whom

said requests may be directed, and shall specify that requests for new hearings may be made at any time within 180 days after receipt of the notice. Defendants shall prepare a form of notice; submit it to the court within fourteen days from the date hereof; and plaintiffs shall file a written response within seven days thereafter. A hearing thereon shall be held on motion of either party, or by the court on its own motion.

DATED: 9 Jul. 1980

/s/ William H. Orrick
WILLIAM H. ORRICK
United States District Judge

APPENDIX C

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

No. C-79-0201 WHO

WILLIAM MCCLURE, ET AL., PLAINTIFFS

vs.

RICHARD SCHWEIKER, Secretary of Health and Human Services, ET AL., DEFENDANTS

Filed Apr. 9, 1981

ORDER APPROVING PLAN FOR IMPLEMENTATION OF JUDGMENT

Good cause appearing,

IT IS HEREBY ORDERED that:

1. Plaintiffs William McClure, Charles Shields, "Ann Doe," and all persons who have received, or shall hereafter receive, Part B hearing officer decisions, unfavorable in whole or part, dated on or after May 1, 1980, shall be entitled to a *de novo* hearing of record conducted by an Administrative Law Judge of the Social Security Administration. These hearing are to be conducted pursuant to the same rules and procedures as hearings on Medicare Part A claims. Said persons may request a hearing within sixty (60) days of receipt of a notice informing them of their right to a new hearing. Said persons are not entitled to further appeal or review of the Administrative Law Judge's decision.

2. Defendant Secretary of Health and Human Services shall take all necessary action to insure that persons entitled to new hearings reopening Part B hearing officer decisions dated from May 1, 1980, until twenty-one (21) days after the date of this Order are mailed a notice of their right to appeal in the form provided in Attachment A hereto, within ninety (90) days of this Order.

3. Defendant Secretary of Health and Human Services shall take all necessary action to insure that all Part B hearing officer decisions dated twenty-two (22) or more days after the date of this Order shall include a notice of the right to appeal in the form provided in Attachment B hereto.

4. Defendant Secretary of Health and Human Services shall take all other necessary action to insure that this Order and the Court's Order of July 9, 1980, are fully implemented, and shall file with this Court and serve on plaintiffs' counsel semiannual reports fully detailing the implementation of the Orders of this Court. Said reports shall commence June 1, 1981, and continue until January 1, 1983, or until further order of this Court.

5. The Court's "Summary Judgment and Order" dated July 9, 1980, is hereby modified as follows:

(a) Page 2, lines 4-6: the text commencing with "all persons" and ending with "filing of this lawsuit" is deleted and replaced by:

> "Plaintiffs William McClure, Charles Shields, "Ann Doe," and all persons whose claims for Part B benefits have been denied by carrier-appointed hearing officers commencing May 1, 1980;"

(b) Page 2, lines 15-16: the text commencing with "all persons" and ending with "hearings at" is deleted and replaced by:

> "Plaintiffs William McClure, Charles Shields, "Ann Doe," and all persons who have received Medical Part B hearing officer decisions dated on or after May 1, 1980, in * * *."

(c) Page 4, line 1: "180 is deleted and replaced with "60."

Dated: April 3, 1981.

/s/ William H. Orrick
WILLIAM H. ORRICK
United States District Judge

ATTACHMENT A

[CARRIER LETTERHEAD]

[Name and Address of Claimant]

Dear ————————:

RE: [Identification of Case]

As a result of a recent federal court decision, all persons who have had their Part B Medicare claims denied in whole or in part by a Medicare Hearing Officer since May 1, 1980, are entitled to a new hearing if they wish. Our records show that you received an unfavorable hearing decision on your claim by notice dated ————————.

If you believe that decision was not correct, you may now request a new hearing before an Administrative Law Judge of the Social Security Administration's Office of Hearings and Appeals. If you want such a new hearing, YOU MUST REQUEST IT WITHIN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE. It will be presumed that this notice has been received 5 days after the date shown above unless you can reasonably show that you did not receive it within 5 days.

You are entitled to be represented by an attorney or other person. Also, you may ask to attend the new hearing in person. If you do not do so, the Part B hearing decision in your case will be reviewed on the record, without the need for your personal appearance. Whether or not you decide to attend the hearing in person, you may submit additional evidence regarding your claim.

In requesting such a hearing, you should state:

1. Your name;
2. Address;
3. Social Security Number;
4. The complete name and address of your representative, if you have any;
5. The name of your servicing carrier (or organization; and
6. The date the Part B hearing officer denied your claim (as shown at the end of the first paragraph of this notice).

You may make your request for a hearing through any social security office. If you visit the office, please take this letter with you.

If you do not want to make your request for a new hearing in person at a social security office, please send your request for a new hearing to:

Office of Hearings and Appeals
Social Security Administration
Director, Division III
P.O. Box 2518
Washington, D.C. 20013

Sincerely,

[Carrier Representative]

ATTACHMENT B

The last page of a Part B hearing officer's decision will carry the message: "Important: See the Next Page for an Explanation of Your Appeal Rights."

YOUR RIGHT TO APPEAL

If you believe the Medicare Hearing Officer's decision in your case is not correct, you may request a new hearing before an Administrative Law Judge of the Social Security Administration's Office of Hearings and Appeals. If you want such a new hearing, YOU MUST REQUEST IT WITHIN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE. It will be presumed that this notice has been received within 5 days after the date shown above unless you can reasonably show that you did not receive it within 5 days.

You are entitled to be represented by an attorney or other person. Also, you may ask to attend the new hearing in person. If you do not do so, the Part B hearing decision in your case will be reviewed on the record, without the need for your personal appearance. Whether or not you decide to attend the hearing in person, you may submit additional evidence regarding your claim.

In requesting a new hearing, you should state:

1. Your name;
2. Address;
3. Social Security Number;
4. The complete name and address of your representative, if you have any;
5. The name of your servicing carrier; and
6. The date the Part B hearing officer denied your claim (as shown on the preceding page).

You may make your request for hearing through any social security office. If you visit the office, please take this notice and the hearing officer's decision with you.

If you do not want to make your request for a new hearing in person at a social security office, please send your request for a new hearing to:

Office of Hearings and Appeals
Social Security Administration
Director, Division III
P.O. Box 2518
Washington, D.C. 20013

APPENDIX D

G. WILLIAM HUNTER
United States Attorney

GEORGE CHRISTOPHER STOLL
Assistant United States Attorney
Civil Division

450 Golden Gate Avenue, Box 36055
San Francisco, California 94102
Telephone: (415) 556-6433

Attorneys for the Defendant

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

Civil Number C-79-0201-WHO

WILLIAM MCCLURE, CHARLES SHIELDS, and "ANN DOE" individually and on behalf of a class of persons similarly situated, PLAINTIFFS

v.

RICHARD S. SCHWEIKER, Secretary of the Department of Health and Human Services and BLUE SHIELD OF CALIFORNIA, DEFENDANTS

Filed May 1, 1981

NOTICE OF APPEAL

The defendant Secretary of the Department of Health and Human Services hereby appeals to the

United States Supreme Court pursuant to 28 U.S.C. § 1252 from the order of the District Court entered in this case on April 9, 1981.

DATED: May 1, 1981

Respectfully submitted,

G. WILLIAM HUNTER
United States Attorney

By /s/ George C. Stoll
GEORGE CHRISTOPHER STOLL
Assistant United States Attorney
Civil Division

Attorneys for the Defendants

I hereby certify that the annexed instrument is a true and correct copy of the original on file in my office.

ATTEST:

WILLIAM L. WHITTAKER
Clerk, U.S. District Court
Northern District of California

By /s/ Tim Jones
Deputy Clerk

Dated 5-1-81

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a conformed copy of the foregoing NOTICE OF APPEAL was this date mailed to attorneys as follows:

HARVEY SOHNEN, ESQ.
Legal Aid Society of Alameda
2357 San Pablo Avenue
Oakland, California 94612

SALLY HART WILSON, ESQ.
NATIONAL SENIOR CITIZENS
LAW CENTER
1636 West 8th Street, Suite 201
Los Angeles, California 90017

PATRICIA BURGESS
P.O. Box 485
Fortuna, California 95540

DIANE M. ROTH, ESQ.
LEGAL AID SOCIETY OF
SAN MATEO COUNTY
221 Broadway
Redwood City, California 94063

Dated: May 1, 1981

/s/ Roberta L. Santiago
ROBERTA L. SANTIAGO
U.S. Attorney's Office

APPENDIX E

I hereby certify that the annexed instrument is a true and correct copy of the original on file in my office.

ATTEST:

WILLIAM L. WHITTAKER
Clerk, U.S. District Court
Northern District of California

By /s/ Cristina Estrella
Deputy Clerk
Dated May 6, 1981

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

No. C-79-0201 WHO

WILLIAM MCCLURE, CHARLES SHIELDS, and "ANN DOE" individually and on behalf of a class of persons similarly situated, PLAINTIFFS

v.

RICHARD S. SCHWEIKER, Secretary of the Department of Health and Human Services and BLUE SHIELD OF CALIFORNIA, DEFENDANTS

Filed May 1, 1981

JUDGMENT

Cross-motions of the parties for summary judgment, and plaintiffs' motion for an order certifying a

class action having been duly brought on to be heard, and this Court having filed its opinion on May 19, 1980 and a Summary Judgment and Order on July 9, 1980;

and pursuant to said Order, the parties' motions for an order approving their respective plans for implementation of judgment having been duly brought on to be heard;

and this Court having filed its Order Approving Plan for Implementation of Judgment on April 9, 1981, which Order modified in part the Court's Summary Judgment and Order of July 9, 1980;

and there being good cause for this court to merge the permanent relief previously set forth in the Summary Judgment and Order filed July 9, 1980 and in the Order Approving Plan for Implementation of Judgment filed April 9, 1981, into one form of judgment and to modify the form of notice, accordingly,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

1. Pursuant to Rule 23(b)(2) and 23(c)(1) of the Federal Rules of Civil Procedure, the present case is certified as a class action consisting of plaintiffs William McClure, Charles Shields, "Ann Doe," and all persons who have received Medicare Part B hearing officer decisions dated on or after May 1, 1980, in which coverage of benefits has been wholly or partly denied, excluding persons who are plaintiffs in other actions currently pending against the Secretary of Health and Human Services which raise issues similar to those raised herein.

2. Medicare Part B beneficiaries are entitled to have final determinations made with respect to their claims by hearing officers who are independent of the

Medicare carriers. Therefore, the current system of Part B hearings provided by the carriers as prescribed by the Medicare Statute, 42 U.S.C. Section 1395u(b)(3)(c) and 1395ff, is declared to be in violation of the United States Constitution, and therefore void.

3. Plaintiffs William McClure, Charles Shields, "Ann Doe", and all persons who have received, or shall hereafter receive, Part B hearing officer decisions, unfavorable in whole or in part, dated on or after May 1, 1980, shall be entitled to a *de novo* hearing of record conducted by an Administrative Law Judge of the Social Security Administration. These hearings are to be conducted pursuant to the same rules and procedures as hearings on Medicare Part A claims. Said persons may request a hearing within sixty (60) days of receipt of a notice informing them of their right to a new hearing. Said persons are not entitled to further appeal or review of the Administrative Law Judge's decision.

4. Defendant Secretary of Health and Human Services shall take all necessary action to insure that persons entitled to new hearings reopening Part B hearing officer decisions dated from May 1, 1980 until April 30, 1981, are mailed a notice on or before July 8, 1981 or their right to appeal in the form provided in Attachment A to this Court's Order of April 9, 1981, as modified by paragraph 7 herein.

5. Defendant Secretary of Health and Human Services shall take all necessary action to insure that all Part B hearing officer decisions dated on or after May 1, 1981 shall include a notice of the right to appeal in the form provided in Attachment B to this Court's Order of April 9, 1981, as modified by paragraph 7 herein.

6. Defendant Secretary of Health and Human Services shall take all other necessary action to insure that this judgment is fully implemented, and shall file with this Court and serve on plaintiffs' counsel semi-annual reports fully detailing the implementation of the Orders of this Court. Said reports shall commence on June 1, 1981, and continue until January 1, 1983, or until further order of this Court.

7. Attachments A and B to this Court's Order of April 9, 1981 are hereby modified as follows:

(a) Attachment A, page 1, line 7: insert after part, the following phrase: "in an amount of $100 or more."

(b) Attachment B, page 1, line 5: insert after If, the following phrase: "your claim is $100 or more and."

DATED: 1 MAY 1981

/s/ William H. Orrick
WILLIAM H. ORRICK
U.S. District Court Judge

Entered in Civil Docket May 5, 1981

APPENDIX F

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

No. C-79-0201 WHO

WILLIAM MCCLURE, CHARLES SHIELDS, and "ANN DOE," individually and on behalf of all others similarly situated, PLAINTIFFS

v.

RICHARD S. SCHWEIKER, Secretary of the Department of Health and Human Services, and BLUE SHIELD OF CALIFORNIA, DEFENDANTS

Filed May 1, 1981

ORDER

This matter is before this Court on defendants' Motion for a Stay of this Court's Order of April 9, 1981, which approved a plan for implementation of judgment and defendants' motion for reconsideration of said Order. For the reasons set forth below, both motions are denied.

Defendants argue that this Court should apply the test for a stay set forth in *Washington Metropolitan Area Transit Commission* v. *Holiday Tours, Inc.*, 559 F.2d 841 (D.C.Cir. 1977). Plaintiffs argue that this Court should apply the test approved by the Ninth Circuit in *Covington* v. *Schwartz*, 230 F. Supp. 249, 252 (N.D.Cal. 1964) *mod.* and *aff'd.*, 341 F.2d 537 (9th Cir. 1965). Under both these cases, the equities of the situation must tip sharply in favor of the defendant, in order for a stay to be granted. This Court finds that the equities of the situation tip in favor of plaintiffs, and thus defendants do not prevail under either test.

First, the movants have not shown that they will be irreparably injured without a stay. This Court's Order requires defendants to allow persons who are dissatisfied with decisions on Medicare Part B claims issued under the existing insurance carrier hearing system to have a right to a *de novo* hearing under the existing Administrative Law Judge system. Defendants have not shown that a substantial increase in cost will result or that the costs of compliance will make up a significant portion of the overall costs of the Social Security Administrative Law Judge system or the Medicare Supplementary Insurance (Part B) program. Defendants have also not shown that denial of a stay will have a substantial disruptive effect on their operations, or that their current system cannot be readily restored if this Court's decision is reversed on appeal.

Secondly, the movants have not shown that a stay will not substantially harm other interested persons. This Court has decided that many elderly and disabled people are being erroneously deprived Medicare benefits that they are entitled to as a result of the unconstitutional Medicare Part B appeals procedures. These deserving recipients may be in dire need and the administrative inconvenience of which the defendants complain cannot justify delaying implementation of hearing procedures that comply with constitutional requirements. Many of the elderly recipients might not survive to benefit from the relief ordered by this Court if a stay is granted. Both courts and legislatures have stated a strong public policy against litigation delays affecting the elderly. Therefore, this Court finds that many of these people would themselves suffer irreparable harm if this Court were to stay its Order.

Thirdly, the movants have not shown that a stay would be in the public interest. The public interest

is better served in denying this motion for a stay, thereby reducing the likelihood that aged and disabled persons will be deprived of Medicare benefits to which they are entitled.

The single disputed issue which this Court must decide with respect to defendants' motion to reconsider is defendants' request that 42 C.F.R. § 405.860 be made binding on Administrative Law Judges when they conduct *de novo* hearings on Part B claims. This Court finds that this rule, which now applies only to insurance carrier-appointed hearing officers, would make Administrative Law Judges subject to conflicting and inconsistent rules if it were extended to them, and that it would be therefore inappropriate to so modify this Court's prior Order. Accordingly,

IT IS HEREBY ORDERED, that defendants' motion for a stay be denied; and it is

FURTHER ORDERED, that defendants' motion for reconsideration of this Court's Order Approving Plan For Implementation of Judgment be denied.

DATED: May 1, 1981

/s/ WILLIAM H. ORRICK
WILLIAM H. ORRICK
U.S. District Court Judge

I hereby certify that the annexed instrument is a true and correct copy of the original on file in my office.

ATTEST:
WILLIAM L. WHITTAKER
Clerk, U.S. District Court
Northern District of California

By /s/ Cristina Estrella
Deputy Clerk
Dated 5-8-81

APPENDIX G

G. WILLIAM HUNTER
United States Attorney

GEORGE CHRISTOPHER STOLL
Assistant United States Attorney
Civil Division
450 Golden Gate Avenue
San Francisco, CA 94102
Telephone: (415) 556-6433

Attorneys for the Defendants

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

Civil No. 79-0201-WHO

WILLIAM MCCLURE, CHARLES SHIELDS, and "ANN DOE," individually and on behalf of a class of persons similarly situated, PLAINTIFFS

v.

RICHARD S. SCHWEIKER, Secretary of the Department of Health and Human Services and BLUE SHIELD OF CALIFORNIA, DEFENDANTS

Filed May 5, 1981

NOTICE OF APPEAL

The defendant Secretary of the Department of Health and Human Services hereby appeals to the United States Supreme Court pursuant to 28 U.S.C.

§ 1252 from the Final Judgment of the District Court entered in this case on May 5, 1981.

DATED: May 5, 1981

Respectfully submitted,
G. WILLIAM HUNTER
United States Attorney

By /s/ George C. Stoll
GEORGE CHRISTOPHER STOLL
Assistant United States Attorney
Civil Division

Attorneys for the Defendants

I hereby certify that the annexed instrument is a true and correct copy of the original on file in my office.

ATTEST:
WILLIAM L. WHITTAKER
Clerk, U.S. District Court
Northern District of California

By /s/ Cristina Estrella
Deputy Clerk

Dated 5-5-81

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a conformed copy of the foregoing NOTICE OF APPEAL was this date mailed to attorneys as follows:

HARVEY SOHNEN, ESQ.
Legal Aid Society of Alameda
2357 San Pablo Avenue
Oakland, California 94612

SALLY HART WILSON, ESQ.
National Senior Citizens Law Center
1636 West 8th Street, Suite 201
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PATRICIA BURGESS
P.O. Box 485
Fortuna, California 95540

DIANE M. ROTH, ESQ.
Legal Aid Society of San Mateo County
221 Broadway
Redwood City, California 94063

DATED: May 5, 1981

/s/ George C. Stoll
GEORGE CHRISTOPHER STOLL
Assistant United States Attorney
A member of the Bar of the United States Supreme Court

APPENDIX H

SUPREME COURT OF THE UNITED STATES

No. A-961

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., APPELLANTS

v.

WILLIAM MCCLURE, ET AL.

ORDER

UPON CONSIDERATION of the application of the Solicitor General and the response filed thereto,

IT IS ORDERED that the orders of the United States District Court for the Northern District of California, case No. C-79-0201 WHO, filed April 9, 1981 and May 1, 1981, be and the same are hereby, stayed pending the timely docketing of an appeal in the above-entitled cause. Should such an appeal be so timely docketed, this order is to continue pending this Court's action on the jurisdictional statement. If the appeal is dismissed or the judgment of the United States District Court for the Northern District of California is affirmed, this order is to terminate automatically. In the event that jurisdiction is noted or postponed, this order is to remain in

effect pending the sending down of the judgment of this Court.

/s/ William H. Rehnquist
Associate Justice of the Supreme
Court of the United States

A true copy
ALEXANDER L. STEVAS

Text:

Clerk of the Supreme Court of the
United States

By /s/ Francis J. Lorson
Chief Deputy

Dated this Twelfth day of June, 1981.

APPENDIX I

SUPREME COURT OF THE UNITED STATES

No. A-961

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., APPELLANTS

v.

WILLIAM MCCLURE, ET AL.

[June 12, 1981]

ON APPLICATION FOR STAY

JUSTICE REHNQUIST, Circuit Justice.

Applicant requests that I stay a judgment of the District Court of the Northern District of California pending a direct appeal of that judgment to this Court pursuant to 28 U.S.C. § 1252. On May 5, 1981, applicant filed a notice of appeal.

This case involves the constitutionality of the hearing procedures available under Part B of the Medicare Act, 42 U.S.C. §§ 1395j-1395w, 1395ff. The Medicare Act is divided into two parts. Part A provides insurance for hospital and related post-hospital services. 42 U.S.C. (& Supp. III) § 1395c; § 1395d. Part B provides a voluntary program of supplementary medical insurance covering, in general, 80% of the reasonable costs of certain other services, primarily physicians services and medical supplies. 42 U.S.C. (& Supp. III) § 1395k; § 1395*l*. The Secretary determines whether an individual is

eligible to enroll in the Part B program, and the individual is entitled to an administrative hearing and judicial review of that eligibility determination. 42 U.S.C. §§ 1395ff(a) and (b)(1)(B). As to the implementation of Part B, Congress authorized the Secretary to enter into contracts with private insurance carriers under which the carriers would determine and pay Part B benefits on a reimbursable basis. 42 U.S.C. § 1395u. Under these contracts, the carriers receive advances of funds, which they then disburse to claimants in reimbursement for medical services found by the carriers to be covered by Part B. 42 U.S.C. § 1395u(c). If a claimant is dissatisfied with the reimbursement allowed by the private carrier, the claimant is entitled to a "fair hearing" conducted by the private carrier if the amount of the claim is $100 or more. § 1395u(b)(3)(C). The Act does not provide for an appeal to the Secretary of an adverse judgment by the carrier after a hearing.

Respondents, a class of Part B beneficiaries, brought suit challenging the constitutionality of that hearing procedure. In a decision rendered May 19, 1980, the United States District Court for the Northern District of California concluded that Congress' vesting of final decisionmaking authority in the carrier violates the claimant's due process rights because, in the court's view, hearing officers selected by the carrier may be biased and because hearings conducted by Administrative Law Judges employed by the Government may be more reliable. In relief, the District Court ordered that any Part B claimant whose claim was finally rejected after a full evidentiary hearing by the carrier's hearing officer on or after May 1, 1980 be given the opportunity for a *de novo* evidentiary hearing before an Administra-

tive Law Judge of the Secretary. On May 1, 1981, the District Court denied the Government's application for a stay of its order pending appeal.

In both form and substance, the District Court has declared unconstitutional an important part of the Medicare statute. Given the presumption of constitutionality granted to all Acts of Congress, I believe that there is a substantial likelihood that four Justices of this Court would vote to note probable jurisdiction of the Secretary's appeal. In addition, because the District Court's remedial order involves a drastic restructuring of the appeals procedure carefully designed by Congress, it will cause hardship to the Secretary. In the application for a stay, the Secretary points out that the day-to-day administration of the Part B program requires a determination of a vast number of individual claims for reimbursement. Indeed, even the District Court noted that, in 1978 alone, more than 124 million such claims were processed. App. to Application, at 12. The cost of providing Administrative Law Judge hearings to dissatisfied claimants will be substantial even if a small percentage of claimants seek such appeals. Indeed, Administrative Law Judges are already overloaded with cases arising under other statutory provisions in which *Congress* has provided for Administrative Law Judge hearings. I thus believe that the Secretary should be relieved of the burden placed on it by the District Court's order until this Court decides whether or not to note probable jurisdiction of the Secretary's appeal.

It is, therefore, ordered that the judgment of the District Court in this case is stayed pending the filing and consideration of the jurisdictional statement challenging that judgment by the Secretary.

☆ U. S. GOVERNMENT PRINTING OFFICE: 1981 381349 559

Joint Appendix

Office - Supreme Court
FILED
DEC 8 1981
ALEXANDER L. STEVAS,
CLERK

No. 81-212

In the Supreme Court of the United States

OCTOBER TERM, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES,

Appellant

v.

WILLIAM MCCLURE, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

JOINT APPENDIX

JURISDICTIONAL STATEMENT FILED JULY 31, 1981
PROBABLE JURISDICTION NOTED OCTOBER 12, 1981

In the Supreme Court of the United States

OCTOBER TERM, 1981

No. 81-212

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES,

Appellant

v.

WILLIAM MCCLURE, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

JOINT APPENDIX

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

Civil Action No. C-79-0201-WHO

RELEVANT DOCKET ENTRIES

DATE	NR.	PROCEEDINGS
1979		
Feb 2	1	COMPLAINT for Mandamus, Declaratory and injunctive relief.
	2	Clerk's order setting conference for 5-4-79/ 1:30pm.
Feb 15	3	EXECUTED return on service of summons as to Blue Shield, 2-9-79
	4	EXECUTED return on service of summons as to J.A. Califano, 2-8-79
Feb 28	5	Defendant BLUE SHIELD's notice of motion and motion to dismiss set for 3-23-79/1:30pm.
	6	Deft BLUE SHIELD's memo of points and authorities. RECEIVED: order.
Mar 6	7	Defendant BLUE SHIELD revised notice of hearing on motion to dismiss reset from 3-23-79 to 4-27-79/1:30pm.
Apr 5	8	Defendant's notice & Motion to change venue set 4-27-79/1:30pm.
	9	Deft's memo in support.
Apr 12		RECEIVED: stipulation & order for continuance of motion
Apr 18	10	STIPULATION & ORDER that Defts motion to change venue and 1st status conference hall be continued to 5-25-79/1:30pm. WHO

DATE	NR.	PROCEEDINGS
1979		
May 15	11	Plaintiff's opposition to motion to dismiss BLUE SHIELD and motion to change venue
May 21	12	Deft BLUE SHIELD's reply memo of points & authorities in support of motion to dismiss.
	13	Deft HEW's reply brief re venue.
29	14	MINUTES (5-25-79): (Reporter C. Pline): Defendant's motion to exclude Blue Shield denied; defendant's motion to dismiss denied; case cont'd to 12-13-79, 5:00pm. for pretrial conference; cont'd to 12-17-79, 9:00am. for trial WHO
	15	ORDER For Pretrial Conference: Trial will begin 12-17-79, 9:00am.; pretrial conference set for 12-13-79, 5:00pm. WHO
Jun 6	16	ORDER: deft's motion to dismiss DENIED without prejudice and that deft's motion to change venue DENIED. WHO.
Jul 9	17	Plaintiffs proof of service by mail—order re motion to dismiss.
Jul 17	18	Plaintiff's interrogatories to HEW.
Jul 18	19	Plaintiff's interrogatories to BLUE SHIELD.
Aug 16	20	Defendant's ANSWER to COMPLAINT.
	21	Defendant's notice and motion for transfer/ stay, set 9-14-79/1:30pm.
	22	Defendant's memo in support of renewed motion to transfer venue or to stay. RECEIVED: Proposed order.
Sep 5		RECEIVED deft notice of substitution of attys.
Sep 10		RECEIVED: Order: re motion to compel.

DATE	NR.	PROCEEDINGS
1979		
Sep 6	23	Plaintiffs memo in opposition to renewed motion to transfer venue or alternatively to stay action.
	24	Defendant BLUE SHIELD's notice of substitution of attys. WHO
Sep 10	25	Defendant's declaration of counsel.
	26	Defendant's reply brief.
Sep 11	27	Plaintiff's supplemental memo in opposition to renewed motion to transfer venue or to stay action. —exhibit B
Sep 12	28	Defendants exhibits to interrogatory responses.
	29	Defendants answers to BLUE SHIELD interrogatories.
	30	Defendants answers to HEW interrogatories.
Sep 14	31	Defendant's certificate of counsel.
	32	MINUTES: (CR/PLINE) Deft's motion for transfer or stay DENIED.
Sep 24	33	STIPULATION & ORDER for substitution of pltf atty.
Sep 27	34	Defendant BLUE SHIELD's addendum to answers to interrogatories.
Oct 11		RECEIVED: Plaintiffs order denying renewed motion to transfer venue.
Oct 30	35	Plaintiff's notice of change of address of counsel.
Nov 20	36	Defendants' Notice of Motion for Summary Judgment set for 12/21/79 at 1:30

DATE	NR.	PROCEEDINGS
1979		
	37	Defendants' Exhibits Memo in Support of Motion for Summary Judgment
Nov 30	38	Plaintiffs appendices to memo of points and authorities in support of motion for summary judgment. RECEIVED: Proposed summary judgment.
	39	Plaintiffs memo in support of motion for class certification.
	40	Plaintiffs motion for order certifying class action.
	41	Plaintiffs motion for summary judgment set 12-21-79/1:30pm.
	42	Plaintiffs memo of points and authorities. RECEIVED: Proposed order certifying class.
Dec 6		RECEIVED: Stipulation suspending pre trial order.
Dec 10	43	STIPULATION & ORDER that order for pre trial preparation be suspended until the motions are heard and determined. WHO.
Dec 11	44	Plaintiff's notice of motion and motion to strike affidavit of Stanley Katz, set 12-21-79/1:30pm. —memo of points & authorities —exhibit A
Dec 13	45	Declaration of Personal service.
Dec 14	46	Plaintiff's notice of motions and motion to proceed by fictitious name set 1-11-80/9:00am.
	47	Plaintiff's memo of points & authorities. RECEIVED: proposed order.

DATE	NR.	PROCEEDINGS
1979		
Dec 31	48	Defendants appendix 2 to reply to memo of points & authorities in support of motion for summary judgment.
	49	Defts response to motion to strike affidavit of S. Katz —exhibit B to memo in support of motion for summary judgment.
	50	Defts reply to memo of points & authorities in support of motion for summary judgment.
	51	Defts reply to memo in support of motion for class certification.
	52	Pltfs response to motion for summary judgment.
	53	Defts reply to memo in support of motion for class certification.
1980		
Jan 4	54	Defendants reply to response to motion for summary judgment.
7	55	Pltfs reply to reply to memo in support of motion for class certification.
	56	Plaintiffs reply to response to motion to strike affidavit of S. Katz.
	57	Pltfs reply to reply to memo of points & authorities in support of motion for summary judgment.
11	58	MINUTES: 1/11/80 (C/R-Pline) Plaintiffs/ defendants motions for summary judgment under submission. Plaintiff's motion to proceed by fictitious name granted. Motion to strike affidavit of Katy denied. WHO
Jan 21	59	Plaintiffs' supplemental brief in support of motion for order certifying class action

DATE	NR.	PROCEEDINGS
1980		
	60	Affidavit re true name of plaintiff Ann Doe (SEALED—IN VAULT)
30	61	Defendants' supplemental reply brief
Feb 5	62	Defendants' Appendix to Supplemental Reply Brief
Mar 21	63	Defendant's notice that related cases in USDC, Central District of California have been stayed pending decision in this case.
May 19	64	OPINION WHO
June 16	65	Defendant's memo in response to plaintiff's proposed summary judgment and order.
25	66	Plaintiffs' Reply Memo re: Proposed Summary Judgment & Order
Jul 9	67	SUMMARY JUDGMENT & ORDER: 1. Case certified as class action. 2. Current system of Part B hearings declared void. WHO
30	68	Defendants' proposed notice to send along with denial letters
Aug 8	69	Plaintiffs' proposed notice re notice on each Part B hearing officer decision
Sep 3	70	Defendants' notice of motion to modify order of 7/9/80 set 9/26/80, 1:30 p.m.
	71	Defendants' motion to modify order of 7/9/80
	72	Defendants' proposed plan pursuant to order dated 7/9/80 Received Order modifying paragraph 5 of Order
8	73	Defendants' renotice of motion to amend set 9/26/80 to 10/3/80.

DATE	NR.	PROCEEDINGS
1980		
Sep 19	74	Plaintiffs' notice of motion/motion for approval of plan set 10/3/80, 1:30 p.m.
	75	Plaintiffs' memo of points in opposition to defendants' proposed plan & defendants' motion to modify, and in support of #74
Sep 23	76	Exhibit A to plaintiffs' memo of points in opposition to defendants' proposed plan & motion to modify, & in support of plaintiffs' motion for approval of plan
29	77	Counsel's request for names & addresses of other attorneys
30	78	Defendant's response to plaintiff's opposition to defendants' proposed plan & motion to modify Court Order of 7/9/80
Oct 2	79	Plaintiffs' reply to defts' response to pltfs' opposition to defts proposed plan & motion to modify Court Order of 7/9/80
Oct 3	80	MINUTES: 10/3/80 (C/R-Pline) Defendant's motion to modify Paragraph 5 of Order of 7/9/80. Cont'd to 10/31/81, 1:30 P.M. for further status. WHO
6		Received Scheduling Order.
8	81	Plaintiffs' deposition notice—Daniel Skolar & all other employees or agents of defendants who will submit affidavits in support of defendants' plan
9	82	Class member counsel's notice of appearance
14	83	SCHEDULING ORDER: 1. Parties to serve upon opposing counsel final proposed plans 2. Plaintiffs to depose affiants to be completed by 10/31/80.

DATE	NR.	PROCEEDINGS
1980		
		3. Parties to file/serve opening cross briefs 15 days after deposition transcripts are received. 4. Closing briefs to be filed 15 days after receipt of briefs. 5. Court will set case for hearing upon filing of briefs. WHO
17	84	Declaration of counsel Received Proposed Order approving plan for implementation of judgments
21	85	Defendants' affidavit of Daniel L. Skoler & attachments
Oct 28		Received Final Briefing and Hearing Schedule
Nov 4	86	ORDER ON FINAL BRIEFING AND HEARING SCHEDULE: Nov. 17, 1980—cross submissions of proposed orders and supporting material. Dec. 1, 1980—cross submissions of comments Dec. 19, 1980—2:30 P.M. — hearing and conference set. WHO
Nov 17	87	Defendant's brief in support of proposed plan following hearing of 10/30/80 Received Order re implementation of Order & judgment dated 7/9/80
18	88	Plaintiffs memo of points & authorities in support of plan for implementation of judgment.
Dec 4	89	Defendants' reply to pltfs' memo in support of pltf's plan for implementation
	90	Plaintiffs' reply to defts' brief in support of defendants' proposed plan

DATE	NR.	PROCEEDINGS
1980		
15	92	Class plaintiffs' counsel's notice of appearance
8	91	Plaintiffs' addendum to reply to defendants' brief in support of defendants' proposed plan
	93	Defendants' motion to strike notice of appearance of Drs. Edward S. Truppman and Jay Ellenby as members of class
19	94	MINUTES: 12/19/80 (C/R-Pline) Hearing re plan for implementation of judgment—order read into record. WHO
29	95	Reporter's transcript, 12/19/80
1981		
Jan 15	96	Letter to Court by Joseph A. Bochenek seeking renewal of hearing against Medicare Carrier, etc.
Apr 9	97	ORDER approving plan for implementation of judgment. WHO
17	98	Defendant's motion to stay Court's Order of 4/9/81
	99	Defendant's brief in support of motion for stay pending appeal
	100	Defendant's exhibits in support of #98
	101	Defendants' motion to reconsider Court's Order approving implementation of Judgment
Apr 22	102	Clerk's notice that defendant's motion for stay of Court's Order of 4/9/81 and to reconsider Order approving plan for implementation of judgment set for hearing on 5/15/81, 1:30 p.m.
27	103	ORDER SHORTENING TIME: Hearing on motion to reconsider Order of 4/9/81 and a motion for stay pending appeal to be heard 5/1/81, 1:30 p.m.

DATE	NR.	PROCEEDINGS
1981		
		Opposition to motion may be filed 4/24/81. WHO
29	104	Plaintiffs' opposition to defendants' motion to reconsider
	105	Plaintiffs' opposition to defendants' motion for stay pending appeal
May 1	106	ORDER: 1. Defendants' motion for a stay denied. 2. Defendants' motion for reconsideration of Court's Order Approving Plan for Implementation of Judgment denied. WHO
	107	JUDGMENT: (See document) Entered 5/5/81 WHO
	108	MINUTES: 5/1/81 (C/R-Pline) Defendant's motion for stay of Court Order 4/9/81 & motion for reconsideration of Order 4/9/81 denied. WHO
5	109	NOTICE OF APPEAL TO SUPREME COURT by defendants. (No fee)
	110	NOTICE OF APPEAL TO SUPREME COURT by defendants. (as amended) No fee.
6	111	Reporter's transcript, 5/1/81
8	112	Plaintiff's proof of service of 106 & 107
June 16	113	Letter to Solicitor General MC Cree re certified copy of order.
July 1	114	Copy of Clerk, U.S. Supreme Court granting Solicitor General's extension of time to docket appeal-time extended to 8/1/81.
Oct 16	115	Certified copy of order from U.S. Supreme Court noting probable jurisdiction of case.

[Exhibit B to Defendant's Memorandum in Support of Motion for Summary Judgment]

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

Civil No. C79-0201 WHO

WILLIAM MCCLURE, CHARLES SHIELDS, and "ANN DOE", individually and on behalf of a class of persons similarly situated, PLAINTIFFS

vs.

JOSEPH A. CALIFANO, JR., Secretary of the Department of Health, Education and Welfare, and BLUE SHIELD OF CALIFORNIA, DEFENDANTS

AFFIDAVIT OF STANLEY KATZ

COUNTY OF BALTIMORE)
) SS
STATE OF MARYLAND)

I, Stanley Katz, being duly sworn, depose and say as follows:

(1) I am the Director, Division of Technical Policy and Litigation, Bureau of Program Policy, Health Care Financing Administration, to which the Secretary of Health, Education, and Welfare (hereinafter referred to as the Secretary) has delegated authority (42 U.S.C. § 4051; § 1395ii; § 1395kk) for the administration of the program of Health Insurance in Title XVIII of the Social Security Act (42 U.S.C. 1395 *et seq.*). At my direction the files of the Health Care Financing Administration have been examined. On the basis of personal knowledge and information

[page 2]

furnished by staff personnel, I believe the following facts to be true and accurate.

AUTHORITY

(2) In accordance with a contract between Blue Shield of California (hereinafter referred to as "carrier") and the Secretary entered into under section 1842 of the Social Security Act (42 U.S.C. 1395(u)), the carrier has responsibility to adjudicate claims (billings for services of physicians or equipment of suppliers located in the area of San Francisco, California) for medical insurance benefits pursuant to the provisions of Part B of Title XVIII of the Act, regulations of the Secretary promulgated thereunder, and general instructions issued by the Bureau of Program Policy of the Health Care Financing Administration to such carriers under contract.

HEARING PROCEDURES

(3) When under contract with the Secretary, section 1842(b)(3)(C) of the Social Security Act (42 U.S.C. 1395u(b)(3)(C)) requires a carrier to establish and maintain procedures pursuant to which a claimant under Part B of Title XVIII is provided an opportunity for a fair hearing, if the amount in controversy is $100 or more, when a claimant is dissatisfied with a prior determination of the carrier as to its denial of the claim or the amount awarded, or if the claimant believes that the request for payment is not being acted upon with reasonable promptness. Because the statute requires the total process of adjudication of Part B claims to be performed by carriers as agents of the Secretary, plaintiffs' claims were adjudicated as set out in the administrative transcript in this case which I certified on October 19, 1979.

(4) While a Hearing Officer appointed by a carrier acts as the agent of the Secretary in adjudicating a Part B claim, he must exercise an independent and impartial judgment as would an Administrative Law Judge (an employee of the Office of Hearings And Appeals

[3]

of the Social Security Administration) who renders a decision under Part A of Title XVIII or Title II of the Social Security Act. In the exercise of such judgment the Hearing Officer performs his adjudicative function independently of the carrier which appointed him, and in the manner of an Administrative Law Judge he is bound to apply pertinent provisions of Title XVIII, regulations promulgated thereunder, rulings and procedures established by the Health Care Financing Administration.

(5) With regard to the claims in these cases, ambulance services are covered and reimbursable only as provided by 42 C.F.R. § 405.232(i) which also includes transportation by aircraft. The reimbursable reasonable cost of covered surgical procedures under Part B, Title XVIII of the Social Security Act are determined pursuant to provision 42 U.S.C. § 1395u(a)(1)(A) and (b)(3)(B); and 42 C.F.R. § 405.502. Surgical procedures for transsexual operations are not covered under Title XVIII, regulations thereunder or policy issuances.

(6) After the carrier has made an initial determination for a Part B claim, the claimant has a right to receive a review determination pursuant to 42 C.F.R. § 405.807 *et seq.* Following this determination the claimant has a right to the statutory fair hearing, 42 U.S.C. § 1395u(b)(3)(C), and determination as set out in 42 C.F.R. § 405.820 *et seq.* The established procedures for the review determination and hearing process are contained in Chapter XII of the Medicare Carriers Manual, i.e. Section 12000 *et seq.* This chapter is attached hereto in full as Attachment A.

(7) Establishment of regulations, standards, policy, procedures, or other requirements are governmental powers exercised only by the Department of Health, Education and Welfare in accordance with delegated authorization by the Secretary and authority of section 1871 of the Social Security Act, 42 U.S.C. § 1395hh.

[4]

(8) In fiscal year 1975 more than 81.5 million Part B claims were processed by carriers under contract pursuant to 42 U.S.C. § 1395u. Such claims process increased to in excess of 124 million claims for fiscal year 1978.

(9) Attachment B hereto contains Part B Appeals Statistics for review determination and hearing determinations for fiscal and calendar years 1975 through 1978. At the review level reversals (in whole or in part) were made in a range of 51% to 58% of the cases considered. At the hearing level to which continued denials are appealed, such cases considered on the merits were reversed (in whole or in part) in a range of 42% to 51%. Cases are dismissed at the hearing level mostly on grounds of lack of jurisdictional amount since a hearing is available only for Part B claims in which the amount in controversy is $100 or more.

(10) In accordance with section 1842(b)(2) and (b)(3)(D), (E) and (b)(4) or the Social Security Act (42 U.S.C. 1395u(b)(2) and (b)(3)(D), (E) and (b)(4)), the Bureau of Program Policy of the Health Care Financing Administration closely monitors the performance of carriers to ascertain that their administrative responsibilities under their contracts with the Secretary with respect to claims under Part B of Title XVIII are properly carried out. This procedure is contained at Section 12023, Chapter XII of the Medicare Carriers Manual referred to in paragraph 6 above.

/s/ Stanley Katz
STANLEY KATZ
Bureau of Program Policy
Health Care Financing Administration
Department of Health, Education
and Welfare

[5]

Subscribed and sworn before me
this 8th day of November, 1979

[SEAL]

/s/ [Illegible]
Notary Public

My Commission expires July 1, 1982

[Attachment A to Affidavit of Stanley Katz]

EXCERPTS FROM CHAPTER XII OF THE MEDICARE PART B CARRIERS MANUAL, DEPARTMENT OF HEALTH AND WELFARE SERVICES

CHAPTER XII

APPEALS PROCESS

[page 12-3]

Review and Hearings

12000. INITIAL DETERMINATION

The carrier evaluates the evidence and makes an initial determination with respect to benefit claims filed under the supplementary medical insurance plan by an enrollee or his assignee. Such determinations include, but are not limited to, determinations as to whether the deductible has been met; whether the itemized bill is acceptable; whether the charges for items or services furnished are reasonable; whether services are medically necessary; etc. A carrier may not make an initial determination with respect to any issue or factor for which SSA has sole responsibility (for example, whether or not an individual is entitled to coverage under the supplementary medical insurance plan; whether an independent laboratory meets the conditions for coverage of services; etc.) or which relates to hospital insurance benefits payable only under Part A as a Part A benefit.

12000.1 *Notice of Initial Determination.*—After a carrier has made an initial determination on a request for payment, a written notice of the determination is sent to the enrollee and/or the assignee, and/or any other entity determined to have an appealable interest in the proceedings. This notice is prepared in accordance with § 7000 and is final and binding upon all parties to the determination unless it is reviewed in accordance with § 12010 or is revised in accordance with § 12100.

12005. REVIEW AND HEARING PROCESS

The following governing principles should be used as guidelines for establishing a review or hearing. These guidelines permit the carrier to operate with latitude yet assure that the methods and procedures employed are consistent with the governing principles established by SSA.

A. *Parties to a Review or Hearing.*—Any enrollee under Part B of Medicare in his own right, or his authorized representative (see § 12019) has the right to request a review or hearing. (See § 12013.1 for the effect of the $100 limitation on a request for hearing.) A physician, supplier, or nonparticipating provider acting as assignee of the enrollee, is also entitled to a review or hearing on the same ground as those afforded the enrollee. An enrollee who assigns his claim for payment for Part B services does not lose his right to a review or hearing and may question the reasonableness of the charge established by the carrier, since this determination affects the amount for which he is responsible under the coinsurance requirement.

B. *Issues to be Acted Upon at a Review or Hearing.*—A review or hearing may be requested whenever there is dissatisfaction with the carrier's determination denying a request for payment or with the amount of the payment under Part B. A hearing may be requested when the request for payment is not being acted upon with reasonable promptness. "Acted upon" means that the carrier made a determination paying or denying

payment of a claim. It will be deemed unreasonable if the request for payment has not been acted upon within a period of 60 days after receipt by the carrier of the request for payment.

C. *Time Limit for Filing an Appeal Request.*—The time limit within which an appeal must be filed for both a review or a hearing is 6 months from the date

of the previous determination notice. Any determination with regard to timeliness of an appeal request or granting of good cause will be made by the carrier in the case of a review request and the hearing officer where a hearing has been requested. In no case will the carrier make any determination with respect to a claim where a hearing has been requested.

* * * *

[12-9]

12010.2 *Elements of a Review.*—The following are the essential elements of an adequate review.

A. Notice of the right to question an adverse decision of the carrier should be provided to the claimant at the time the carrier acts on a request for payment. The notice of the claims action should contain an appeals paragraph, an example of which can be found in part F of this section.

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The claimant may also be referred to a social security office for assistance in writing out his complaint. The social security office staff will give the claimant general program information, and if he wishes to request a review of the decision, will help him complete a Form SSA-1964. (See § 12015.)

B. The employee who made the initial determination should not be the one to review the case.

C. The purpose of the review is to provide a new, independent, and critical reexamination of the claim. Therefore, the reviewer should make a new examination of each aspect of the claim. He should look not only at the point at issue, but at the entire claim.

D. The claimant is to be given an opportunity to submit any relevant and material evidence and is to be instructed to submit evidence and statements in writing by mail or through any SSO. The carrier should request additional evidence from the claimant and/or the physician, provider or other supplier of services if necessary for proper adjudication.

E. Since one of the purposes of instituting the review is to reduce unnecessary costs, the review does not provide for personal appearance and testimony by the claimant.

F. The determination after review is to be in writing and is to be mailed to the claimant (and any other party involved). The notice states the basis for the review determination (i.e., why payment is or is not being made), and advises the claimant of his right to request a hearing if he is not satisfied with the review determination and the amount in controversy is $100 or more. The notice should inform the beneficiary that claims may be combined with other claims that have been reviewed or reopened (see §§ 12100.12 regarding reopening) within 6 months of the date of the hearing request to meet the $100 limitation. The following appeal paragraph should be included in the review determination:

> "If you are still dissatisfied with this review determination, you may request, within 6 months of the date of this notice, a hearing before a hearing officer if the amount in controversy (the amount of benefits in question) is $100 or more. To meet the $100 limitation, you may combine other claims of yours that have been through the review or reopening process within 6 months of the date of the hearing request. This request must be sent either to this office or to any social security office. Either office will be glad to assist you in requesting a hearing."

G. The review determination is the final determination unless a hearing is requested or it is revised in accordance with § 12100.

H. All carrier actions in the review of a claim are fully documented and the file includes all correspondence, papers, requests, reports, etc., arising out of the claims review process. This file will be necessary if a hearing is requested.

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[12-12.2]

12015. REQUEST FOR HEARING

Any individual dissatisfied with a review determination, and in some cases with a revised determination (see § 12100.12), or with the length of time the carrier takes to act on the initial claim (see § 12015I), may request a hearing in accordance with C below. A qualified representative (see § 12019A) may file the request for hearing on behalf of any such individual whom he represents. Also, a representative or executor of a deceased claimant's estate may file a request for hearing. (See § 12019C.)

Each request for hearing must be disposed of by the HO in one of the following ways:

(1) Conducting a hearing;

(2) Making a determination on the record (see § 12020G);

(3) Dismissing the request (see § 12015K);

(4) Accepting a withdrawal at the request of the claimant or representative;

(5) Transferring the request to another carrier HO if an out-of-area hearing has been requested (see § 12015B); or

(6) Transferring the request to the RO where the issues are outside the HO's responsibility (see § 12014).

A. *Carrier's Responsibility in Handling a Request for Hearing.*—The HO acquires jurisdiction immediately upon the claimant's filing a request for hearing. At this point, the carrier is to forward all material to the HO without rendering a second review determination. Also, the carrier is to acknowledge the hearing request as soon as possible, but no later than 10 days after receipt, and notify the beneficiary or representative that the HO will be contacting him about his request for hearing.

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The carrier may provide clerical or technical assistance to ensure completeness of the file before sending it to the HO. However, the carrier does not render a decision. The ultimate responsibility for the hearing determination is the hearing officer's. In rare instances, upon receipt of a hearing request the carrier may find an obvious clerical error, receive new and material evidence, or find an error on the face of the evidence, the correction of which would result in a fully or partially favorable decision to the beneficiary. For example, evidence may have been requested during the review process regarding a complicated surgical procedure which is received subsequent to the review determination. Even though such evidence may justify payment in excess of the original reasonable charge amount, payment to the beneficiary is not to be made at this point. Instead, all evidence should be sent to the HO. The beneficiary is not to be encouraged to withdraw the request. Reimbursement would be made only after the HO's disposition of the hearing request.

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[12-21]

12016. HEARING OFFICER (HO)

A. *Authority.*—The HO occupies a significant position in the administrative appeals process affording dissatisfied individuals hearing rights as provided in section 1842(b)(3)(C) of the Act. Authority of the HO is limited to the extent that he must comply with all provisions of title XVIII of the Act and regulations issued thereunder, as well as with HCFA rulings, general instructions and other guides issued by HCFA or the Medicare Bureau. The HO does not have the prerogative of overruling the provisions of the law or of interpreting them in a way different than that of the Medicare Bureau when he is in disagreement with their intent; nor may he use hearing decisions as a vehicle for commenting upon the legality, constitutional or other-

wise, of any provision of the Act or regulations relevant to the Medicare program. (See § 12022B regarding carrier's effectuation of the HO decision.)

B. *Qualifications and General Responsibilities.*—The carrier should designate as a HO an attorney or other qualified individual with the ability to conduct formal hearings and with a general understanding of medical matters and terminology. The HO must have a thorough knowledge of the Medicare program and the statutory authority and regulations upon which it is based, as well as rulings, policy statements, and general instructions pertinent to the Medicare Bureau.

The individual selected to act in the capacity of HO must not have been involved in any way with the determination in question and neither have advised nor given consultation on any request for payment which is a basis for the hearing. Since the procedings are of a nonadversary nature, be particularly responsive to the needs of unrepresented parties and protect the claimant's rights, even if the claimant is represented by counsel. The parties' interests must be safeguarded to the full extent of their rights; in like manner, the government's interest must be protected.

The HO should conduct the hearing with dignity and exercise necessary control and order. In order to render a proper decision, the HO must analyze and evaluate evidence adduced at the hearing, including testimony, documents or other written evidence included in the hearing record. The HO must make independent and impartial decisions, write clear and concise statements of facts and law, secure facts from individuals without causing unnecessary friction, and be objective and free of any influence which might affect impartial judgment as to the facts, while being particularly patient with older persons and those with physical or mental impairments.

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The Hearing Officer is obliged to consider all relevant and material facts. The written decision should contain a statement of the issues, evidence, rationale, specific findings of fact and a conclusion, within the framework of applicable law, regulations and guidelines.

The HO should schedule the hearing timely in an effort to render a decision within 90 days after receipt of the hearing request. For the HO to perform his function properly, adequate prehearing preparation is essential. (See §§ 12017ff.) The HO should bring unusual problems he encounters to the attention of the regional office.

The HO shall fully document in the hearing file any reasons for delays in holding the hearing or rendering a decision, when it appears that a decision will be rendered more than 90 days after the request for hearing is received.

The following sections discuss HO functions in more detail.

C. *Disqualification of Hearing Officer.*—The HO should disqualify himself from acting in a case in which he might be considered prejudiced or partial; or with respect to any matter in which he has a personal interest; or in which a valid objection is raised by a party. Disqualification would be appropriate where a HO was involved in any way in the initial or review determination.

Reluctance to handle a particular case is not sufficient justification for disqualification. The HO should withdraw only for cogent reasons, keeping in mind primarily the objective of his position which is to afford a claimant the opportunity for an impartial hearing. Participation in a factually similar or related case normally would not be reason for disqualification.

The point is sometimes raised by claimants that a HO is an employee of the carrier. Even if true, this fact is not good cause for disqualification. The HO should indicate that although he is not an officer of the Federal Government he is nevertheless acting on its behalf and must comply with the provisions of the Medicare law, regulations, and instructions.

Where a party to a hearing suggests disqualification of the HO, the party's request should be included as part of the record. The record should also show the HO's disposition of the allegation. When the HO, on his own volition or upon objection of a party, does disqualify himself from acting in a case, he should prepare and insert in the hearing file a signed statement setting forth the reasons.

When the HO withdraws on his own volition prior to scheduling the case for hearing, no notice to the parties of such withdrawal is necessary since they will not be aware of his action. When the HO disqualifies himself as a result of party's objection, the HO will inform the claimant and any other party to the action of his withdrawal and that in due course the case will be heard by another HO. If a notice of hearing has been issued prior to withdrawal, the HO will notify all parties of his action by letter, informing

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them that the date set for the hearing has been cancelled (if cancellation is necessary) and that they will receive an amended notice of hearing from the HO to whom the case is reassigned. If the motion for withdrawal and actual withdrawal occur at the hearing, the oral statements made part of the record will be sufficient. In a situation where a party's prehearing protest is considered and the HO decides to preside at the hearing, he will so advise the protesting party in writing, setting forth his reasons for doing so. A copy of his action

must be sent to any other appropriate party. If his ruling not to withdraw is made at the hearing, a statement for inclusion in the record will be sufficient.

12017. PREPARATION FOR THE HEARING

For the HO to be fully informed, it will be necessary to consider certain aspects of the claim prior to the hearing and, preferably, before the notice of hearing is mailed. The first step in preparing for the hearing is an examination of all the evidence, including evidence or statements submitted with the claimant's hearing request. (Where development of evidence is necessary see paragraph C of this section.) Once the HO has ascertained the completeness of the evidence and the issues to be determined at the hearing, he should examine the applicable sections of the law, regulations, rulings, policy statements, general instructions and any other formal guides pertaining to the issues under appeal.

A. *Notice of Time and Place of Hearing.*—A claimant who requests a hearing is to be given adequate written notice of the time and place set for the hearing and information regarding the specific issues to be determined. The notice is to be sent to the claimant as promptly as possible, subsequent to the HO's review of the evidence.

Where the hearing was requested by counsel or other representative of the beneficiary, notice must be given to that person. Where a physician or other assignee has requested a hearing, effort should be made to notify the beneficiaries (assignors) of the hearing time and place if they may have been found liable for payment of the amount in controversy.

The hearing should be scheduled at a time and place mutually convenient to the claimant or his representative and the HO. The HO should ensure that the location and time of the hearing will not infringe upon the beneficiary's right to a hearing. In some instances, a

beneficiary's physical condition may require the scheduling of a hearing at a hospital or other convenient location.

The notice of hearing should be sent at least 14 days prior to the date of the hearing, and should contain sufficient information about the hearings procedures for the parties to prepare effectively for the hearing. The

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beneficiary's right to be represented by counsel or other representative of his choice should be explained in the notice. Failure to adequately inform the claimant of the nature and purpose of the hearing, with specificity as to the points at issue, may result in denying him an essential element of the hearing. Therefore, particular care must be taken in phrasing this information to be sure that the wording can be easily understood by a layman while being technically correct and complete.

The notice should contain the following elements:

1. The time of the hearing;
2. The place of the hearing, giving city, state, street address, floor and designated room;
3. The purpose of the hearing and a statement of the issues;
4. A brief statement of the consequences of the proceeding and of the decision which will follow it;
5. If necessary, reference to the particular statute or regulation which is authority for the hearing;
6. If appropriate, particular procedural rights to present briefs or affidavits in lieu of testimony; rights to present oral argument; the effect of abandonment or failure to appear, etc.;
7. Parties may be represented by counsel or other representatives;
8. Parties may bring witnesses;
9. Parties should bring all evidence in their posses-

sion, including pertinent records, documents or other writings affecting the issues;

10. Notification that the beneficiary should promptly notify the HO in writing of any circumstances preventing the beneficiary from making a personal appearance, or of any objection to the time and place of the hearing.

11. When an attorney or other person will be representing the beneficiary send a copy of an SSA-1696 (Appointment of Representative) form with instructions that the form should be completed.

The HO should include a copy of the notice of time and place of hearing in the hearing file.

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[12-25]

C. *Review of the Evidence.*—Once a request for hearing has been filed, the carrier should submit to the HO all evidence pertaining to the claim. The carrier's rationale for denying a payment request is an issue which must be resolved at the hearing and, consequently, the carrier should comply with all requests for evidence by the HO.

While the claimant, in the final analysis, is responsible for securing the needed evidence to establish his claim, the HO must protect the claimant's rights by making every effort to insure that sufficient evidence is obtained. The HO should appraise the evidence in the file and any other documentary evidence that may reach him before the hearing is scheduled, from the standpoint of its adequacy as proof of the questions at issue, in order to select the documentary evidence to be used as exhibits in the hearing record.

Where it is apparent from the examination of the file that evidence on some point is conflicting, inconclusive or wholly lacking, the HO must consider how the desired evidence may best be procured before scheduling the

hearing. The HO must consider the need for having a consultative physician or other expert witness. In order to avoid delay which might result from the absence of a key witness or the lack of some essential evidence, he should make every effort to ensure that all evidence and witnesses will be available at the time and place set for the hearing. The HO may obtain additional evidence which he regards as necessary to the complete development of the case, through appropriate channels from the carrier, physician, hospital, or other source.

If the HO does not receive requested evidence or information after two 30-day follow-up requests, he should make a decision on the evidence at hand. Should he receive the evidence after the decision has been rendered, the HO may reopen his decision. (See §§ 12100ff).

Because the hearing is an relatively informal proceeding as contrasted to court proceedings, evidence may be considered even though it might be inadmissible under rules of evidence applicable to the courts (see § 12020). The pertinence, materiality and relevance of the evidence are the controlling criteria with respect to admissibility of evidence in hearings, rather than the particular form in which it appears.

Any doubt with respect to whether a particular document should be selected as an exhibit may usually be resolved in favor of its use.

Determining the issues and selecting the documentary evidence are especially important where the claimant waives the right to appear and a hearing must be based on the record. (See § 12020G.) The HO should have

prepared sufficiently for the hearing to be able to make a determination based on the record in the event a claimant waives his right to appear.

12018. CONDUCT OF HEARING

Admission to the hearing as well as the conduct of the hearing falls within the purview of the HO. The hearing should be open to the parties and to such other persons as the HO deems necessary and proper for the orderly and efficient conduct of the hearing.

In conducting the hearing, the HO is to guide the hearing, observe witnesses, and develop all the facts necessary to reach a just decision. In so doing, he builds a record on the disputed points which will be adequate to sustain a decision. To this end, he is primarily responsible for questioning the witness and at the same time ensuring that the parties to the hearing are permitted to ask pertinent questions and provide testimony which has not been previously elucidated. He may also request the attendance of witnesses whom the parties have not suggested, if their testimony appears to be necessary. He is also charged with the responsibility of setting proper limits in each case to the argument which the parties are permitted to make.

The control of disorderly or contemptuous conduct rests with the HO. When difficult situations arise, the HO may properly exercise whatever controls he believes necessary, including adjournment, to maintain the dignity and decorum of the hearing.

12019. PARTIES TO THE HEARING

According to the Medicare Regulations section 405.802, the term "party" is defined as "a person enrolled under Part B of title XVIII, his assignee, or other entity having standing in the initial or appellate proceedings." A party to the hearing is any person (or persons) who was a party to the review or revised determination and any other person whose rights to Part B benefits may be prejudiced by the hearing decision. These individuals would include members of the beneficiary's immediate family or the executor of a decedent's estate. The beneficiary who

received the medical services is always a party to the hearing, as well as any physician or other person who furnished services under the supplementary medical insurance plan *and* who has accepted a valid assignment executed by the beneficiary.

A. *Representatives of the Party.*—A party to the hearing may appoint an attorney or other individual to act as his authorized representative, unless prohibited by law.

A representative may exercise any and all of the rights given to parties on behalf of the person he is representing. Notice of any action, request for evidence, or decision is to be sent to the representative, where one has been appointed by the beneficiary. The representative may file or give any appropriate notices for his party. Either the representative, the party, or both may attend the hearing.

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D. *Other Persons Present at Hearing.*—

1. *Witnesses.*—A person who attends a hearing as a witness may not insist on testifying, interpose objections, or make comments during the proceeding. The subject matter and scope of the individual's testimony is for the HO to decide under evidentiary rules applicable to administrative proceedings. Considerable latitude is allowed and any party or his representative has the right to question any witness following his testimony.

[12-28]

Witnesses may be permitted by the HO to remain in the room as spectators either before or after they have testified. However, the HO may exclude any witness whose subsequent testimony might be influenced by what is transpiring, or whose presence might disrupt the hear-

ing. If the HO determines it to be necessary, he may ask a witness to be present at the hearing only during his testimony. Where the HO's pre-hearing review of a case reveals that the expert opinion of a medical or other specialist will be needed, arrangements for the acquisition of such expert opinion may be made through carrier channels. The cost, if any, of a consultative opinion is an administrative cost to be borne by the carrier under the Medicare program. Apart from fees provided for an expert witness or for translation services, there is no provision for reimbursement of fees or other related expenses incurred by hearing participants.

2. *Carrier Witness.*—An employee or a consultant of the carrier who appears at a hearing does so with the status of a witness, and he is bound by the restrictions placed on witnesses, despite the fact that a carrier witness will have specialized information to offer. The HO should follow normal procedure with the witness and avoid informal discussion.

Attendance of a carrier witness is occasionally necessary to explain the reasoning behind the carrier's initial and review determinations and to answer the claimant's questions. When a physician/supplier is to be present, the presence of a carrier consultant of the same specialty may be required in order to rebut the testimony of the physician/supplier.

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12020. HEARING PROCEDURES

The HO must be cognizant of the informal nature of a Part B hearing and notify the claimant or his representative that there are major differences between an administrative hearing and a formal court proceeding. The hearing is nonadversary in nature in that neither the carrier nor the Medicare Bureau is in opposition to the

party but is interested only in seeing that a proper decision is made. Therefore, formal objections and other accepted court procedures are not appropriate. Rules of evidence and proof are less restrictive than in a court, and their emphasis is different from those used in court. The HO's role is that of a trier of the facts and he may consider as evidence any testimony or documentation which would enable him to make a fair decision. The HO may also question participants to the hearing in order to develop evidence and establish the facts. New evidence may be presented throughout the hearing, witnesses may be asked to testify again, parties need not make a final statement, and a party always has the right of rebuttal after evidence adverse to his case has been presented.

A. *Rights of a Party at the Hearing.*—The rights which a party may exercise at a hearing stem from his basic right to an independent hearing where he can appear personally and are as follows:

1. The right to present oral arguments and/or written statements as testimony;

2. The right to be represented by an attorney or other qualified individual of his choice;

3. The right to bring witnesses to testify on his behalf;

4. The right to bring and present all evidence in his possession, including pertinent records, documents, or other writings affecting the issues;

5. The right to question witnesses and other parties; and

6. The right to examine the evidence and to register objections to the inclusion of any document in the record. The parties at the hearing should already be aware of these rights at the time the hearing commences. However, if it appears to the HO that a party is not being afforded due process because he is not exercising his

rights, the HO may review them for the benefit of those present at the hearing.

[12-30]

Inspection of the evidence should take place prior to the hearing, if possible, so that parties may prepare for the case in advance. However, if the hearing itself is the only time available, the inspection should take place before the testimony. A party examining evidence should always do so under the supervision of the HO or a person chosen by him to see that nothing is removed, defaced, or added. When additional information is furnished after the hearing, parties must have the opportunity to read it and comment upon it.

B. *Opening the Hearing.*—The hearing should be formally opened by HO's reading of an opening statement. (See paragraph C below.) Before making the opening statement, the HO should identify the parties, their representatives and witnesses, and enter their names, official titles and interest in the record of the hearing. It is advisable for the HO to introduce himself and his stenographer, to the others present, explaining briefly that he will preside at the hearing and that the stenographer will take down that what is said or use some other method to record the hearing.

Before testimony the HO should briefly summarize the purpose of the hearing and the issues involved. If any party, or his representative, disagrees with the summary of the purpose and the issues, he is to be heard. After hearing the reasons for disagreeing, the HO may modify the summary, if he believes a change is warranted.

C. *Opening Statement.*—The hearing commences with an "opening statement" by the HO. It sets the tone for the hearing and focuses attention upon the purpose of a hearing and explains how it will be conducted. The HO may wish to prepare the statement in writing in advance of the hearing. (See § 12999, Exhibit 7 for a sample opening statement.)

While the contents of the opening statement must be drawn from the facts of the particular case, the following should be included in every opening statement:

1. Identification of the hearing by giving the names of the participants, account number(s), issue(s) involved, and the statement that the hearing is now open;
2. The party's right to a hearing;
3. Identification of the HO in a statement of authorization for conduct of the hearing;
4. The hearing will be conducted in an informal manner, and the formal rules of evidence are not applicable;

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5. The procedural history concerning pertinent facts and dates, including facts revealed by documents in the carrier file, e.g., entitlement to coverage under the supplementary medical insurance plan established, deductible met, services covered;
6. The issues to be resolved should also be stated, as well as the pertinent sections of the law and regulations and how the issues relate to the law;
7. Discussion of the penalty provision (see § 12020D) for providing false or misleading statements; and
8. Explanation of the formal aspects of the hearing in that:
   a. a formal record of the proceeding will be made;
   b. the record will consist of the documentary evidence and the testimony;
   c. only one person will testify at a time;
   d. the witnesses may be cross-examined; and
   e. the parties may submit a statement or brief of proposed findings at the end of the testimony or after the close of the hearing.

While this outline represents the contents of a typical opening statement, circumstances may require modification at various points. Any relevant occurrence or situation that warrants special mention should be included.

After reading the opening statement, the HO will ask the participants whether his opening statement is a correct account of what has happened and whether they regard it as accurately defining the issues. If any misunderstandings are evident in the participant's responses, the HO should make an attempt to clarify them by suitable explanation.

D. *Oaths, Affirmations, and the Penalty Provision.*—The HO has no authority to administer either oaths or affirmations. However, at some point during the opening statement, the HO should advise the parties and witnesses of the penalties for perjury or misrepresentation during the hearing.

Section 1877 of the Social Security Act provides in pertinent part that "Whoever . . . at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment . . . shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than 1 year, or both."

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E. *Principles of Questioning.*—The bulk of the questioning is usually done by the HO. Interrogations facilitate the proceedings by pinpointing the issues and eliminating the irrelevant and immaterial. This method also acts as an aid to a hesitant and inarticulate witness. The degree of participation in the interrogation of a participant by the HO will be determined by a number of factors, one of which would be the representation of the parties by counsel. In most instances, questioning by the HOs will be less necessary when all parties are represented by counsel.

The order of proof followed should be flexible and will depend in large part on the case. Witnesses may be questioned and requestioned as the HO deems necessary

or as the need arises. Generally, the requesting party begins with his testimony or that of his witness(es).

The HO should focus on evaluating the documentation submitted in light of the reliability or nonreliability of the source, the factors present which may limit the impartiality or accuracy of the statements, and whether the evidence is compatible or in conflict with the other evidence in the file. The HO must determine the completeness of the evidence, and where a difference of opinion exists, whether there is sufficient documentation for him to make an impartial judgment on the issue.

F. *Transcript of Hearing.*—A transcript of each hearing must be made. It may either be typewritten or tape recorded, using a cassette.

Ordinarily, there will be little reason to go off the record. It may occasionally be desirable to do so for clarification, simplification, or to eliminate discussion on a matter about which there is no dispute. The record is to include an explanation for going off the record when such a procedure is used.

When directed by the HO, the carrier, or the Medicare Bureau, copies of the hearing testimony and other documentary evidence are to be reproduced. When the Medicare Bureau requests a hearing transcript for sample review purposes (see § 12023C), the initial carrier is to transcribe the hearing.

Where a copy of the hearing is requested by the claimant or his representative, a duplicate cassette should be offered, pointing out the time and money saved by accepting the cassette rather than the transcribing the record. Where a typewritten copy is requested, a copy of the hearing transcript will be provided if the claimant will pay the cost. However, waive the charge if the cost of the transcript is $25 or less, in accordance with the DHEW Privacy Act Regulation (45 C.F.R. Part 5b.13).

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[12-34]

I. *Close of Hearing.*—Because some participants may not be aware of the procedure followed, the HO should advise the parties that the decision is not given at the hearing. He or she will write a decision setting forth his or her findings and the reasons therefore. Parties should be told that the decision will be rendered as quickly as possible and that each party and representative will receive a copy.

Before declaring the hearing closed, the HO should ask whether there is further evidence to be presented, either immediately or later, and whether the claimant and other parties want to examine any evidence which may be received. The HO should then state that the hearing is closed. If evidence of substantial nature which could affect the hearing determination is received subsequent to the close of the hearing, the HO may reopen the hearing at a later date.

12021. HEARING DECISION

As soon as practicable after the close of a hearing, the HO should make a decision in the case based upon the documents, requests, papers, or other written evidence included in the hearing record. The decision should be in writing, and contain a statement of the issues; the evidence with reference to exhibits, where appropriate; the rationale; specific findings of fact; and a conclusion. The claimant, because of his interest in the matter, will expect to receive a prompt decision and the HO should arrive at a determination as expeditionsly as possible, preferably within 30 days of the close of the hearing. (See § 12999, Exhibit 8, for a sample hearing determination.) Where payment has been denied in assigned claims because services were not reasonable and necessary, or were custodial in nature, the HO is to consider whether the waiver of liability provisions under section 1879 of the Social Security Act would permit payment. (See §§ 7300ff.)

A. *Limitations.*—The HO's decision must comply with the provisions of title XVIII of the Social Security Act, related regulations, as well as with policy statements, instructions, and other guides issued by the Health Care Financing Administration or the Medicare Bureau. (See section 405.860 of the Medicare Regulations.) Where the HO rules upon an issue other than that which is to be determined at the hearing, or otherwise exceeds his statutory authority, the decision may be reopened and revised in accordance with § 12022.

In accordance with regulation section 405.835, the HO's decision is final and binding upon all parties to the hearing unless it is reopened and revised. However, the HO's decision is not a precedent opinion and does not affect subsequent hearing decisions or alter the carrier's payment determination on future claims.

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[12-35]

C. *Style.*—The decision should be written in a formal and impartial tone, but should not be unnecessarily "legalistic." The language used should be simple and clear. An explanation of the decision, if it is to have any value for the claimant, must be easily understandable.

However, correctness should not be sacrificed for simplicity. Where law or regulations support a point in the decision, they should be cited.

D. *Contents.*—Certain basic terms of information should always be included in the hearing decision. These are:

1. A clear statement of the issues involved in this case;

2. A statement of the evidence with reference to the exhibits, where needed;

3. The applicable law or regulation with citations and reference to other appropriate guidelines;

4. A discussion or explanation of the law and the evidence in the case;
5. Specific findings of fact;
6. The decision;
7. The signature of the HO.

E. *Copies.*—A cover letter indicating the results of the hearing with the decision attached will be mailed to the last known address of each party attending the hearing and his authorized representative. The HO will retain one copy of the cover letter and the decision for his records and incorporate copies in the hearing file.

Where a decision has been rendered on an assigned claim and the beneficiary (assignor) has been found liable for the payment, the beneficiary should receive a copy of the hearing decision. If an assigned claim involves several beneficiaries (assignors who have been found liable for the overpayment), each beneficiary should receive a copy of the hearing decision as it relates to his particular claim.

12022. REOPENING AND REVISION OF HEARING DECISION

While a HO's decision is final and binding, the regulations provide for the reopening of a decision under certain circumstances. Either upon the motion of the HO or upon petition of any party to a hearing, a HO may reopen and revise his decision in accordance with section 405.841 of the Medicare Regulations. A decision by a HO may be reopened only by that HO unless he is unavailable for reasons including death, termination of employment, illness, or leave of absence. In that event, a decision may be reopened by another HO selected by the carrier. (See § 12100 regarding reopenings and revisions.)

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Where a decision is reopened it is not always necessary to schedule a hearing in the regular manner. It is suf-

ficient if the claimant, or his representative, is notified in writing that revision of the decision is proposed with respect to a specific finding and asked if he has further documentary evidence or testimony to submit. If he wishes to present further testimony, a modified notice of hearing should be issued to provide the claimant an opportunity to be heard. It may be fairer to a claimant and more expeditious to schedule a hearing if it appears that the revised decision will be unfavorable to him.

A. *Notice and Effect of Revised Decision.*—A revised decision requires the same notice and distribution of copies to those individuals who were parties to the hearing decision.

A revised decision should be so captioned, but the extent of actual revision depends upon the circumstances of the particular case. Generally, it will be sufficient to refer to the date of the original decision and that part which the HO proposes to revise, and give the reasons for the revision, including a statement of applicable law, summarization of additional evidence and rationale, and the specific finding as revised. Any additional evidence, as well as the revised decision, should be incorporated as part of the record.

B. *Carrier's Effectuation of Hearing Officer's Decision.*—Where a HO's decision results in additional payment to the claimant, the carrier is to give written notification to the HO when payment has been made.

In rare situations, a carrier may believe a hearing decision should not be implemented because the HO exceeded his authority in issuing the determination. Although a carrier is not a party to a hearing and cannot make a motion to reopen, where a carrier discovers a case where the HO has exceeded his jurisdictional authority, the carrier must request that he reopen the determination giving specific citations of the applicable law, regulations, and general instructions.

The carrier should contact the regional office where uncertainty exists as to whether the HO has exceeded his authority. If the RO concurs, the carrier should request that the HO reopen the case. Where the matter cannot be resolved at the regional level, contact by the regional office should be made with the Civil Litigation and Hearings Branch, 469 East Building, Baltimore, Maryland 21235.

12023. MEDICARE BUREAU EXAMINATION OF HEARING RECORDS

To help assure uniform application of due process principles in the hearing process and to assist in identifying areas in which the expansion or revision of guidelines is necessary, the Medicare Bureau examines records of hearings conducted by HOs. This review is generally on a sample basis. The following instructions set forth the procedures for forwarding to the Medicare Bureau the copies of the Hearing Information Sheets and the hearing files.

[12-37]

A. *Submission of Medicare Hearing Information Sheets.*—The HO should reproduce and submit a complete Medicare Hearing Information Sheet to the Medicare Bureau for each hearing conducted. This should be sent at the same time the hearing decision is mailed to the party(ies). An exhibit of the information sheet and instructions for its completion are located in § 12999, Exhibit 10. A copy of the completed information sheet is sent to the following address:

Health Care Financing Administration
Medicare Bureau
Technical Issues Branch
127 East Building
Baltimore, Maryland 21235

ONLY THE INFORMATION SHEET IS SENT TO THE TECHNICAL ISSUES BRANCH; COPIES OF CASE MATERIALS ARE NOT TO BE INCLUDED.

B. *Submission of Hearing Files.*—The carrier is to submit a sampling of hearing files to the Civil Litigation and Hearings Branch on a quarterly basis. The complete file consists of the Medicare Hearing Information Sheet, the decision, the hearing transcript, and copies of all exhibits. If a cassette recording was made at the hearing, do not submit a copy of the cassette, but rather submit a copy of the typed transcription instead.

1. During the second month of each quarter, the Civil Litigation and Hearings Branch notifies all carriers of a random number which is to be matched with the last numeral of the beneficiary's health insurance claim number for each hearing case in which there was a decision or dismissal issued during the previous quarter. For each HO, the carrier submits copies of only those hearing cases for which the last numeral matches the designated number. (For exception see 2 below.) In this manner, the Medicare Bureau is assured of receiving a random sampling of hearing records. The records should be sent to the Medicare Bureau no later than 10 working days after receipt of the designated number.

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NOTE: Hearing files in which an out-of-area HO rendered a decision are also to be sent to the Medicare Bureau, but only when the last digit of the HIC number matches the random sample number. The following paragraph does not apply to such cases.

2. Hearing files must be received for each HO who rendered a hearing decision during the quarter. If a HO rendered decisions for fewer than four hearings during the quarter, copies of all his or her hearing records for the quarter should be submitted to the Medicare Bureau. If the HO has completed four or more hearings

during the quarter and none matches the number given by the Civil Litigation and Hearings Branch, copies of the files of any two hearings completed by that HO during the quarter should be submitted. A hearing involving multiple beneficiaries is considered as one hearing and may be used in the sample if any one beneficiary's health insurance claim number matches. However, if two or more hearing records not connected with the multiple beneficiaries can be submitted, the hearing involving multiple beneficiaries' should not be included. A maximum of four decisions per HO are to be submitted. Where more than four decisions match the sample number, any four may be considered for inclusion in the sample.

3. A covering memorandum addressed to the Civil Litigation and Hearings Branch should be used to transmit the files to the Medicare Bureau. In the memorandum list the beneficiary's name, HI number, decision date, and name of the HO for each case being transmitted. (See § 12999, Exhibit 9.)

4. The memorandum and cases should be sent to:

Health Care Financing Administration
Medicare Bureau
Civil Litigation and Hearings Branch
469 East Building
Baltimore, Maryland 21235

Although under this plan the Medicare Bureau reviews only those sample hearings submitted, carriers nevertheless should ensure that all records are complete and accessible since from time to time the Medicare Bureau makes special requests for hearing records, e.g., cases in which a congressional inquiry has been received. Since time is an important factor in such cases, the carriers should be able to quickly forward copies of such records to the Civil Litigation and Hearings Branch.

Please note that copies of the records, including a typed transcription of the hearing should be forwarded, while the original is retained in accordance with § 5404. All records forwarded should be complete, legible, and arranged in chronological order in an individual case folder marked with the beneficiary's name and HI number.

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PART B APPEALS STATISTICS

			Total Claims Cleared	Total Requests Received	Total Requests Cleared	% of Requests Cleared To Claims Cleared	Cases Cleared: Affirmed	Cases Cleared: Dismissed Or Withdrawn	Cases Cleared: Reversed	$ Amt. of Reversal	Av. Amt. Per Reversal*
Fiscal Year Data	Review Data	FY'75	81,577,781	850,836	851,232	1.0	410,417(45%)	7,906(0.9%)	432,849(51%)	$24,838,671	$ 57
		FY'76	93,737,592	1,070,608	1,051,435	1.1	502,814(48%)	9,293(0.9%)	539,328(51%)	32,121,403	60
		FY'77	110,310,283	1,363,215	1,343,694	1.2	618,216(46%)	9,569(0.9%)	716,100(53%)	41,332,968	58
		FY'78	122,491,639	1,495,724	1,495,544	1.2	618,364(41%)	5,169(0.9%)	872,011(58%)	50,733,829	58
	Hearing Data	FY'75	81,977,781	11,461	8,992	0.01	3,121(35%)	3,561(40%)	2,310(25%)	434,316	210
		FY'76	93,737,592	12,675	12,213	0.01	4,346(36%)	4,451(36%)	3,416(28%)	660,099	224
		FY'77	110,310,283	20,278	17,037	0.02	5,492(32%)	6,356(37%)	5,239(31%)	975,223	187
		FY'78	122,491,639	20,137	19,160	0.02	5,703(30%)	7,497(39%)	5,960(31%)	1,124,578	200
Calendar Year Data	Review Data	FY'75	87,918,769	967,204	937,607	1.1	460,759(51%)	7,719(0.9%)	428,129(48%)	29,223,757	53
		FY'76	99,731,322	1,151,191	1,138,954	1.1	557,692(49%)	12,091(0.9%)	569,201(50%)	35.[illegible],975	63
		FY'77	113,305,089	1,416,415	1,407,364	1.2	628,412(45%)	7,732(0.9%)	771,220(54%)	41,196,516	56
		FY'78	125,319,928	1,470,199	1,480,297	1.2	596,650(40%)	7,851(0.9%)	875,636(55%)	53,[illegible],923	61
	Hearing Data	FY'75	87,918,769	12,805	10,733	0.01	3,683(34%)	4,352(41%)	2,698(25%)	695,156	225
		FY'76	99,731,322	14,328	14,204	0.01	4,872(34%)	4,804(34%)	4,528(32%)	1,058,689	234
		FY'77	113,305,089	20,928	16,883	0.01	5,323(32%	6,848(41%)	4,712(27%)	1,017,148	216
		FY'78	125,319,928	20,120	19,953	0.02	6,947(30%)	7,301(37%)	6,810(33%)	1,240,050	158

Information as available and reported by carriers.

[Attachment C to Affidavit of Stanley Katz]

[Appendix B to Plaintiffs' Memorandum of Point and Authorities in Support of Motion for Summary Judgment]

EXCERPTS FROM PART B HEARING OFFICERS HANDBOOK, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE (1972)

* * * * *

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HEARING OFFICER QUALIFICATIONS

The hearing officer:

1. should be competent, qualified and impartial
2. should be familiar with medical matters and terminology
3. should have a thorough knowledge of the program and the regulations issued thereunder
4. should be trained for the responsibilities of his position
5. should not have been previously involved in the case in any manner
6. should exercise patience and tact
7. should possess judicial temperament.

HEARING OFFICER RESPONSIBILITIES

The hearing officer occupies a significant position in the administrative appeals process affording dissatisfied individuals hearing rights as provided for in section 1842 (b) (3) (C). The hearing officer acts as both judge and jury. Sometimes he may be counsel also for unrepresented parties and it is his responsibility to get all the facts and to apply

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the appropriate law, regulations, policy, and guides and reasoning therefor fairly and judiciously. The hearing officer must also deport himself in the discharge of his

duties in accordance with the accepted canons of judicial ethics.

The hearing officer shall be responsible for rendering a written decision in all cases, and such decision shall be supported by findings of fact based upon the evidence adduced at the hearing.

It is the responsibility of the hearing officer to conduct the hearing in such order and manner with such methods of proof and interrogation as he deems best suited to ascertain the substantial rights of the parties, according all parties full opportunity to present such testimony and to introduce such evidence as may be pertinent to the issues involved. He must exercise such control as is necessary for conduct of an effective and reasonably expeditious procedure. The control of hearings to achieve program objectives calls for the exercise of common sense. While the hearing is informal it should be conducted with dignity and decorum. Informality should not be synonomous with chaos. Persons should be made to feel at ease in making statements or with giving testimony, being allowed to speak freely without unnecessary interruption. However, they should be required to adhere to the issues. The hearing officer should so conduct the hearing as to give a clear impression that it is an informal and searching inquiry into the facts of the case. The desired conduct of the hearing officer is to steer a middle course between rigid, formal, technical procedure and careless informality. Freedom from technicality does not release the hearing officer from the necessity of exercising an intelligent judgment on what is pursuasively relevant or material.

The hearing is not adversary (unless there is more than one claimant with conflicting rights) since the carrier and thus the Social Security Administration, or Railroad Retirement Board, has no interest in the result in any case except that a proper decision be made based upon an adequate record, appropriately compiled.

The hearing officer has a basic responsibility for protecting the rights of a claimant even though the claimant is represented by counsel. Although the claimant has the burden of proof in establishing his entitlement to benefits, the hearing officer must see that there is adequate development of all the reasonably available evidence. This, of course, requires the cooperation of the claimant and his counsel, if he is represented, in undertaking to furnish evidence which is reasonably within his ability to secure.

Hearing officers' decisions, as well as prior administrative determinations by the carrier, must be made under the applicable provisions of the law, regulations, and appropriate guides. It is not within a hearing officer's province to pass upon the legality, constitutional or otherwise, of any provision of the act, regulations or policies and procedures issued thereunder by SSA or RRB.

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OATHS AND AFFIRMATIONS

There is no provision for administering either oaths or affirmations by the hearing officer. However, the hearing officer should advise the participants of the penalty for providing false or misleading statements in his opening statement.

Section 208 of the Social Security Act provides in pertinent part that "Whoever at any time makes or causes to be made any false statement or representation of a material fact for use in determining rights to payment under this title, shall be guilty of a misdemeanor and upon conviction thereof, shall be fined not more than $1,000 or imprisoned for not more than 1 year, or both."

Section 1872 of the act provides that section 208 quoted above is applicable to title XVIII to the same extent as it is applicable to title II.

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OPENING THE HEARING

The hearing should commence promptly at the time fixed in the notice of hearing. Delays cause unnecessary irritation to all concerned. The hearing should be formally opened by the hearing officer reading aloud

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the opening statement. He should ascertain the identity of the parties and their representatives and witnesses. He then should have recorded in the minutes of the hearing as well as on his notes, the name, the official title and the interest of each person appearing. It is also advisable for the hearing officer to introduce himself and his reporter (if any) to the others present, explaining briefly that he will preside at the hearing and that the reporter (if any) will take down what is said (if some other method is used to record the hearing, the hearing officer should adjust his remarks accordingly).

Before taking testimony the hearing officer should make a brief summary of the purpose of the hearing and the issues involved. If any party or his representative disagrees with the summary of the purpose and the issues, he should be heard; any necessary modifications should be made by the hearing officer. Where the nature of the proceeding necessitates it, the hearing officer may request the carrier representative to outline the issues of the case instead of doing it himself.

As a preliminary precaution, the hearing officer should not discuss the case with anyone before officially commencing the hearing. Even though he knows all of the personnel who will represent the carrier in the hearing, he should not carry on any conversation with them, either official or social, in the presence of other parties and representatives. As innocent as this may be, experience has shown that this can give an erroneous and harmful impression. The outsider will frequently claim

that the exchange between the hearing officer and his fellow employees gave obvious proof that the hearing officer was prejudiced against the outside party. For the same reason in the course of the hearing, the hearing officer should address his fellow employees in a formal manner and not use first names or nicknames. In addition, the hearing officer should not discuss the case with parties or their representatives prior to the commencement of the hearing. Such exchanges are not on the record, and experience has shown that parties may claim that material statements have been omitted from the record to their detriment.

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Hearing Decision

As soon as practicable after the close of a hearing, the hearing officer is to make a decision in the case based upon the documents, requests, papers or other written evidence included in the hearing record. The decision is to be in writing and is to contain a statement of the issues, a statement of the evidence with reference to exhibits where appropriate, a statement of the applicable law with appropriate citations, a statement of rationale, specific findings of fact, and a conclusion. The hearing officer's decision must comply with the provisions of title XVIII of the act and related regulations as well as with general instructions (e.g., policy statements, instructions and other guides) issued by the Social Security Administration. The hearing officer's authority is definitively restricted by these parameters. A copy of the decision is to be mailed to each party to the hearing at his last known address. The hearing officer's decision shall be final and binding upon all parties to the hearing unless it is revised in accordance with § 405.841. The law does not provide for an appeal to the Social Security Administration from the hearing officer's decision or for judicial review by State or Federal courts of the decision.

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[Appendix H to Plaintiffs' Memorandum of Points and Authorities in Support of Motion for Summary Judgment]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
REGION I

MEMORANDUM DATE: December 19, 1977

TO : Al Fox, Medicare Beneficiary Relations Advisor
Medicare Bureau, Baltimore

FROM : Donald E. Wilson, Program Officer
District Office & Professional Groups
Medicare Bureau, Boston

SUBJECT: Beneficiary Appeals Study

Attached, please find a copy of our beneficiary appeals study conducted in this region from April through September of this year.

We apologize for the delay as other priorities prevented us from making a more timely report.

/s/ Donald E. Wilson
DONALD E. WILSON

Enclosure

cc: Tera Younger, ARMD
Stanton Collins, COB
Keith Dryer, FLO, Balt.
W. Tyssowski, Program Operations, CO
W. McQuay, Standards & Reports Branch, CO
R. Sawatzky, CO

[1]

Study of Requests for Review

For the past six months, the Boston Regional Office has been involved in a study of appeals filed with the Region I carriers as a result of denied claims, both assigned and non-assigned. This study came about as a result of several discussions with Central Office regarding the number of appeals filed by beneficiaries. Statistical data indicated that only 1.5% of beneficiaries filed appeals on denied claims; however, 50% of the appeals filed were reversed in the beneficiaries' favor.

We were concerned as to the reasons why so few beneficiaries request an appeal. One of the obvious reasons for inaction could be a failure to understand the instructions regarding the right to appeal. There are possibly many people, who even though they understand their right to appeal, are turned off or discouraged by district office or contractor personnel for various reasons. Undoubtedly, still others do not pursue their rights because of the relatively small amounts involved. Based on the above statistical data, Central Office was considering a nationwide effort to increase the number of beneficiary filed appeals.

However, the Boston Regional Office felt that before the Medicare Bureau attempted to increase the number of requests for Part B informal reviews, there should be a study of the *reasons* for the high reversal rate on appeal so that proper remedial action could be taken, if warranted, to decrease the number of denials made by carriers during the initial adjudication of Medicare claims. We felt that this type of approach, designed to correct problems with Medicare claims determinations at the front-end rather than simply adding on a layer of costly appeals processing, would seem to offer a better long-term improvement in the delivery of the Medicare program to beneficiaries.

Thus, we felt that an in-depth examination of the appeals process at our carriers might help identify improvements needed in the carriers' initial claims processing systems. If improvements could be effected at the front-end, they would reduce the number of denials which would otherwise have to be corrected on appeal.

While planning this study, our office also felt it would be a worthwhile endeavor to include a review of appeals filed by providers (physicians, DME suppliers, etc.) regarding assigned denied claims, and then compare this data with that relating to non-assigned claims. For purposes of this report reasonable charge reductions are considered denials.

This study was for the express purpose of analyzing why informal reviews are filed, what types of denials are involved, what is the outcome of the review, and lastly, what was the basis of the decision rendered. To do this, we requested each carrier in Region I to pull a sample of

[2]

60-75 informal reviews on assigned and non-assigned cases in order to record the basic information mentioned above. The samples to be pulled were randomly selected by staff at each carrier. One carrier, Rhode Island Blue Shield, misinterpreted instructions and selected certain denied claims in each category (reasonable charge, not medically necessary, etc.) for us to review. Thus, the sample we reviewed was not truly selected at random and the results, by our own admission, are somewhat distorted.

Findings

At several of the carriers, we found that initial non-assigned claims decisions were reversed as a result of an appeal without any additional evidence submitted by the beneficiary. On the basis of an appeal

request, the carrier reviewed and reversed its initial decision. This implies that the carrier could have made the correct decision initially if its procedures called for added development at the front-end to insure a correct decision. It also raises a question concerning coding instructions at initial adjudication since many denials were effected based on incorrect coding. This was especially apparent in the assigned claims. As shown on charts #3 and #4, the reversal rate for non-assigned denied claims is significantly lower overall than that for assigned denied claims (chart #5). As a result of this study, we found that the issues on which an appeal was requested vary greatly in the assigned and non-assigned categories. For example, we found that the average Medicare beneficiary does not understand such concepts as "reasonable charge reductions", global fee", "concurrent care", or even what services are not covered under the program. Thus, many beneficiaries file appeals on issues where the carrier has made the correct decision but the beneficiary lacks knowledge to understand the basis for the denial. In several instances the carrier had erroneously coded a claim, causing an incorrect reasonable charge reduction which was reversed on appeal. The beneficiary, however, filed the review based on the reduced allowance and not on the true reason, that is, improper coding.

For assigned claims, the reversal rate overall was substantially higher. This, we feel was due to the fact that physicians, suppliers, etc., are more aware of procedure codes, coverage issues and can more readily identify genuine errors in the carriers' claims processing. In addition, we feel physicians, etc., are more aware of what types of information the carriers would need to reverse an initial denial and submit such information with their request for review. Rarely was this information verified through requesting operative reports, lab tests, etc.

[3]

One reason for the high reversal rate of several of the carriers is the practice of treating as review requests, inquiries that would result in reopenings and adjustments at other carriers. Most carriers, who as a result of answering an inquiry, discover an error in a claim determination, correct it immediately, and do not have the beneficiary pursue the appeals process. While this does not change the fact that there was an error, it does distort the reversal rate. Nevertheless, additional staff time and reprocessing must take place. This is true in both the assigned and non-assigned areas.

Recommendations

1. Those denials for which the rate of reversal on appeal was particularly high (e.g., reasonable charge, unable to obtain information, duplicate billing, non-covered service, and not medically necessary) would suggest that the carrier's adjudicative procedures need to be examined to determine whether they need revisions. It would also be useful to determine whether there is a correlation between the types of claims processing errors identified by our study of appeals and the types of errors identified by the Part B End-of-Line (EOL) system.

   The fact that a large percentage of the denials reversed on appeal were reversed *without* additional evidence suggests that the carrier *could* have made the correct determination at the time the claim was initially adjudicated if its procedures and/or staff had been such as to assure a correct determination at the time the claim was initially adjudicated if its procedures and/or staff had been such as to assure a correct determination. This should be pursued, particularly for those denial reasons for which the reversal rate without additional evidence was particularly high (e.g., reasonable charges, unable to obtain information, not medically necessary, duplicate

charges) and appropriate corrective action undertaken.

2. We recommend a more intensified effort to contact as many beneficiary groups as possible, throughout the country, to provide them with the needed background and information regarding the Medicare program. We feel this would increase beneficiary awareness vis-a-vis issues that can be appealed and those that should not and provide the carriers with fewer routine appeals which they must again deny.

3. The Boston Regional Office recommends that similar in-depth reviews of the appeals process should be performed at *all* carriers with

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the objective of identifying changes needed at the front-end of the claims process to improve the accuracy of initial determinations *before* the Bureau launches a campaign to encourage beneficiaries to file more requests for appeal. The Bureau would be vulnerable to adverse publicity if increased appeals resulted in as high or higher rate of reversal. Our study reveals that with increased appeals the reversal rate would remain at least as high.

4. The Boston Regional Office feels that additional followup action is necessary to discover what motivates beneficiaries to file or not file appeals. We recommend a second phase of this appeals study to be implemented to provide additional information regarding the appeals process. An outline of the second phase of our study is as follows:

   a. Identify a group of beneficiaries who have recently had their Medicare claims denied for various reasons and who have instituted action appealing the decision.

   b. Identify a group of beneficiaries who have recently had one or more Medicare claims denied

for various reasons and who had taken no action to appeal the denial. This may prove to be more difficult as explained later.

To accomplish a and b, develop a questionnaire aimed at finding:

1. Was denial understood and accepted?
2. If not, was additional information requested and from whom?
3. Was beneficiary satisfied with the additional explanation received from contractor, SSO, or provider of service?
4. If not, was he/she aware of informal review process?
5. If yes, why did he/she not file?

We feel this information would assist us in exploring the motives and initiatives that led to action or lack of action by beneficiaries. Such information would also assist in our training endeavors as outlined in recommendation #2.

[5]

We have contacted several of our carriers regarding this project and have learned that identifying denied claims on the basis of individual reasons for denial (reasonable charge, non-covered service, etc.) would be extremely difficult as all claims data must be pulled manually. However difficult, this project would be extremely worthwhile in that it would assist the Bureau in determining why appeals are/are not filed and possibly save the Bureau additional processing costs. In Region I, it now costs an average of $3.10 to process an initial claim but costs at least $4.75 to process a request for review. In addition, several carriers handle inquiries concerning denied claims as "reopenings", therefore, it costs at least $3.10 to reprocess these.

One conclusion drawn from this study, which we have not expounded upon, is the fact that many beneficiaries are losing program benefits because they are not requesting reviews. Also, our concerns, as developed in this study, which are the result of claims processing errors—either through omission or commission, are echoed through increased Congressional inquiries and adverse publicity. We also feel that this has a direct bearing on the decrease in the assignment rate.

We feel that Central Office needs to give this matter immediate attention and that we would be available to discuss our results and recommendations.

EXHIBITS TO PLAINTIFFS' MEMORANDUM IN SUPPORT OF MOTION FOR CLASS CERTIFICATION

EXHIBIT A (Table):

Table 3: National Data on Part B Hearings Held and Reversed, CY 1968-1975

Calendar Year	Hearings Actually Held		Hearings Reversed		
	Number	Percent of Hearings Processed	Number	Percent of Hearings Processed	Percent of Hearings Held
	(a)	(b)	(c)	(d)	(e)
1968	[1]	[1]	110	19.3	[1]
1969	[1]	[1]	246	19.0	[1]
1970	[1]	[1]	653	24.2	[1]
1971	[1]	[1]	1,480	29.0	[1]
1972	[1]	[1]	1,694	19.7	[1]
1973	5,747	69.9	2,535	30.8	44.1
1974	4,936	65.3	2,235	29.6	45.3
1975	6,381	59.5	2,698	25.1	42.3

[1] Information not available for this period.

EXHIBIT B (HEW's Supplemental Answer to Interrogatory No. 12 in *Gadsden* v. *Califano*, Civil No. C-75 2946 ALS (C.D. Cal):

Interrogatory No. 12

Number of hearings actually held and percentage of hearings requested under Medicare Part B (Interrogatory No. 39-m, answered in Exhibit "Q", column a).

Answer to Interrogatory No. 12

	a	b
calendar year 1976	9,400	66.2
calendar year 1977	10,035	59.4
calendar year 1978	12,657	63.4

EXHIBIT C (HEW's Supplemental Answer to Interrogatory No. 14 in *Gadsden* v. *Califano*, Civil No. C-75 2946 ALS (C.D. Cal):

Interrogatory No. 14

Number of reversals in favor of claimant at hearing under Medicare Part B (Interrogatory No. 39-n, answered in Exhibit "Q", column c).

	c	e
calendar year 1976	4,528	48.2
calendar year 1977	4,712	47.0
calendar year 1978	6,610	52.2

EXHIBIT D (Table):

Table 1—Blue Shield denials, 1977-June, 1979

	(a) Hearings actually held (Interrog. 57(n), *McClure*)	(b) # Reversals in favor of claimant (Interrog. 57(o), *McClure*)	# of denials aff'd (a-b)
1977	278	134	144
1978	487	255	232
June 1979	223	164	59
		TOTAL:	435 denials, Part B Medicare

* Table 2—HEW—Nationwide figures re denials, 1973-1978

	(a) Hearings actually held	(b) # Reversals in favor of claimant	# denials aff'd (a-b)
1973	5747	2535	3212
1974	4936	2235	2701
1975	6381	2698	3683
1976	9400	4528	4872
1977	10,035	4712	5323
1978	12,657	6610	6047
		TOTALS:	25,838 denials, Part B Medicare

* Information obtained from HEW's Answers to Interrogatories in *Gadsden* v. *Califano*, Civ. No. C 75-2946 ALS (C.D.Cal.)

SUPREME COURT OF THE UNITED STATES

No. 81-212

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

WILLIAM MCCLURE, ET AL.

Appeal from the United States District Court
for the Northern District of California

The statement of jurisdiction in this case having been submitted and considered by the Court, in this case probable jurisdiction is noted.

October 13, 1981

☆ U. S. GOVERNMENT PRINTING OFFICE: 1981 339140 691

Motion to Dismiss or Affirm

IN THE SUPREME COURT OF THE UNITED STATES

No. 81-212

October Term, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES,

Appellant,

vs.

WILLIAM McCLURE, CHARLES SHIELDS, and "ANN DOE", individually and on behalf of a class of persons similarly situated.

APPEAL FROM
THE UNITED STATES DISTRICT COURT
FOR THE
NORTHERN DISTRICT OF CALIFORNIA

MOTION TO AFFIRM

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COUNTER-STATEMENT OF QUESTION PRESENTED

Whether the claims appeal procedure of Part B of the Medicare program, which vests final, unreviewable decision-making power in a hearing officer who is appointed by and serves at the will of the same private insurance carrier who has previously denied the claim, violates the impartial hearing officer requirement of the due process clause of the Fifth Amendment and constitutes an unlawful delegation of judicial power of the United States in violation of Article III, Section I of the Constitution.

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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

WILLIAM McCLURE, CHARLES SHIELDS, and "ANN DOE", individually and on behalf of a class of persons similarly situated.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

MOTION TO AFFIRM

Appellees, pursuant to Rule 16(1)(c) and (d) of the Rules of the Supreme Court of the United States, move that the judgment of the United States District Court for the Northern District of California be affirmed on the ground that it is mani-

fest that the question on which the appeal of this case rests is so unsubstantial and the decision below is so obviously correct as to render further argument unnecessary.

COUNTER-STATEMENT OF QUESTION PRESENTED

Whether the claims appeal procedure of Part B of the Medicare program, which vests final, unreviewable decision-making power in a hearing officer who is appointed by and serves at the will of the same private insurance carrier who has previously denied the claim, violates the impartial hearing officer requirement of the due process clause of the Fifth Amendment and constitutes an unlawful delegation of judicial power of the United States in violation of Article III, Section I of the Constitution.

CONSTITUTIONAL PROVISION INVOLVED

In addition to the constitutional and statutory provisions cited in appellant's Jurisdictional Statement (Jur. St. 2-3), appellees wish to add one supplemental provision.

1. Article III, Section 1 of the United States Constitution provides in pertinent part:

> "The judicial Power of the United States, shall be vested in one Supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish...."

STATEMENT

Appellees do not take issue with the statement of the facts as set forth in the appellant's Jurisdictional Statement, but do wish to supplement that statement with

the following information.[1/]

In describing the current Part B appeals procedure, appellant fails to note that appeals are so rarely used by Medicare beneficiaries that only a small fraction of the claims require a hearing conducted by insurance-carrier appointed

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[1/] Appellees do, however, disagree with appellant's characterization of the district court's opinion in two respects. (Jur. St. at 8, 9.) While the appellant describes the second basis for its holding in terms of the unreliability of the Part B hearing system, the district court's holding was actually based on the improper delegation of the judicial function to a private business without right of appeal. (See the court's opinion, Appendix A to appellant's Jurisdictional Statement, at 2a, 15a, 16a.) The court's original holding did not involve an order that Administrative Law Judge (ALJ) hearings be provided. In fact, the court noted that a number of options by way of relief were available to appellant. (Jur. St., App. A at 16a.) Subsequently, after the submission of plans by the parties, the court ordered relief as described more fully below.

hearing officers. For example, in 1978, out of approximately 125 million claims, only 1.2% of the claimants asked for "review", the first level appeal, where a second carrier employee reexamines the initial determination of the claim without holding any hearing. Of the claims that were reviewed in 1978, approximately 1.5 million nationally, only 20,000 or 1.3% of the claimants who requested reviews subsequently requested hearings, and of those, 7,301 requests were dismissed or withdrawn without a hearing.[2/] Thus, the number of persons affected by this decision is fewer than 20,000 per year, of whom a small percentage can be expected to request new hearings.

[2/] Attachment B to Affidavit of Stanley Katz, Exhibit B to Defendants' Motion for Summary Judgment, filed November 20, 1979.

Both Part A and Part B of the Medicare program were enacted in 1965 as Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq. The enrollment in Part B is only slightly smaller than that of Part A.[3/] Indeed, a 1972 amendment to the Medicare program provided that persons who become eligible for Part A are automatically enrolled in Part B as well, unless they take some affirmative steps to decline enrollment before coverage starts. 42 U.S.C. §1395p, 42 C.F.R. §405.210(b).

3/ According to 1979 Health Care Financing Administration statistics, there were 27,858,742 persons enrolled in either Part A or Part B, which included 27,459,157 enrolled in Part A and 26,757,329 enrolled in Part B. United States Department of Health and Human Services, Health Care Financing Administration, Health Care Financing Notes, Persons Enrolled for Medicare, 1979, Table 1, Jan. 1981.

In contrast to the Part B system, the Part A system, which Congress also placed under the administration of insurance companies, utilizes Social Security Administration Administrative Law Judges (ALJ's) to conduct hearings on claims appeals when the amount at issue is more than $100. The $100 minimum also applies to Part B hearings. As with Part B hearings, Part A hearings are the next stage of review after the insurance company reconsiders its initial claims determination. Since the $100 jurisdictional amounts are the same for both programs, both Part A and Part B hearings will concern claims of varying amounts. Appellant's assertion that Part B claims are "of ... relatively small amount" is thus misleading. (Jur.

St. at 11.)[4/]

Indeed, Part A cases often raise issues that will also arise at Part B hearings. Many medical procedures lead to both Part A (e.g., hospital bill) and Part B (e.g., physician's fee) claims being filed. The resolution of these claims consequently depends on common factual and/or legal determinations.[5/]

[4/] Appellant cites no legislative history indicating that Congress was trying to keep small claims from H.H.S. (Jur. St. at 11, n.7.) Indeed, the equal jurisdictional minimums for both programs is evidence to the contrary. It should also be noted that Part B claims hearings may involve large amounts of money. See, e.g. Petition for a Writ of Certiorari, U.S. v. Erika, Inc., No. 80-1594 (U.S., May 16, 1981)(cert. granted), where two Part B hearings concerned an aggregation of similar small claims claimed to total in excess of $200,000 (p. 35a), and in excess of $586,583 (p. 54a), respectively.

[5/] For example, the issue of whether the entire medical procedure is "medically necessary" in connection with 42 U.S.C. §1395y(a)(1) is a common issue in appeals under both programs.

Social Security Administration ALJ's are all experienced lawyers who are trained in administrative adjudication, and have a particular expertise in medico-legal matters, as a high percentage of their caseloads involve disability issues arising under Title II, 42 U.S.C. §401, et seq. and Title XVI, 42 U.S.C. §1381, et seq. of the Social Security Act. Moreover, unlike carrier-appointed hearing officers, ALJ's have fixed compensation, are tenured, and are independent of the private entities administering Medicare.

Cognizant of these facts, the district court rejected appellant's proposal to judicially create a new bureaucracy foreign to the Medicare program generally,[6/] and ordered that persons who were

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6/ Appellant's proposal, which would create a new hearing corps composed of assistants to Administrative Law Judges to either substitute for

dissatisfied with the decisions of the insurance company hearing officers could, if the amounts at issue were above the jurisdictional minimum for ALJ hearings, request such hearings for a de novo review of their claims. Thus, the court order leaves the Part B system entirely intact. It simply adds a layer of appeal, and entails no qualitative alteration of either the Part B carrier hearings or the ALJ system.

6/ (cont.)
Part B hearing officers or provide de novo appeals, is set forth in the Affidavit of Daniel L. Skoler. (See Jur. St. at 10, n.5.)

ARGUMENT

A. THE UNDISPUTED FACTS ABOUT THE MEDICARE PART B HEARING SYSTEM SHOW THAT IT DEVIATES FROM WELL-ESTABLISHED CONSTITUTIONAL STANDARDS.

Appellant's Jurisdictional Statement characterizes the question presented as substantial because, in appellant's view, the district court's decision was based solely on "unfounded speculation that carrier hearing officers may be biased and that ALJ hearings in HHS might reduce the risk of erroneous decisions". (Jur. St. at 11.) A careful reading of the opinion and judgment of the court below reveals that this appeal simply presents the narrow issue of whether the court below correctly applied settled principles of law to an uncontested factual record about

the operation of the Medicare Part B appeals system. The appellant simply characterizes this factual record differently than did the district court. The issue presented by appellants is so unsubstantial and the decision below is so obviously correct as to mandate summary affirmance.

The Medicare Part B hearing system has three characteristics which make it a unique departure from traditional notions of fair procedure in the operation of a decision-making tribunal. First, there is a statutory delegation of the judicial function not to an administrative agency, but to a private insurance company which holds a government contract. Secondly, the hearing officer's decision is not subject to appeal to either the Secretary of H.H.S. or the courts.[7/] Thirdly, the

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7/ Even aside from all overtones

hearing officer, whose function is to review a claim which the carrier has twice denied, is appointed by that same carrier and serves at will, without any protection whatsoever against retaliatory dismissal or assurance of being allowed to serve in the future.

7/ (cont.)

of bias of hearing officers, we note that the delegation here is unprecedented. Delegation of judicial authority to private persons has traditionally been tolerated only where there is a wide scope of judicial review. See Liebmann, Delegation to Private Parties in American Constitutional Law, 50 Indiana Law Jornal 650, esp. 695-708 (1975). Indeed, complete preclusion of judicial review by Congress is quite rare. Wright, Miller, and Cooper, Federal Practice and Procedure, Jurisdiction §3528 (West, 1975).

B. THE DUE PROCESS REQUIREMENT OF AN IMPARTIAL TRIBUNAL IS VIOLATED BY THE HEARING OFFICERS' ASSOCIATIONS WITH THE CARRIER AND BY THEIR PECUNIARY INTERESTS.

Bearing these unique characteristics in mind, the district court in its opinion adhered to the well-established principle that due process requires that a tribunal, whether judicial or administrative, must be impartial. Tumey v. Ohio, 273 U.S. 510 (1927); Ward v. Village of Monroeville, 409 U.S. 57 (1972); Gibson v. Berryhill, 411 U.S. 564 (1973). The most recent decision of the Court striking down a tribunal in violation of the requirement of impartiality, Connally v. Georgia, 429 U.S. 245 (1977), illustrates how well-settled this pinciple is. In Connally, the

Court summarily reversed a decision of the Supreme Court of Georgia in a per curiam opinion. Moreover, the Court has noted that it should be even more scrupulous in safeguarding impartiality with respect to tribunals that, as in this case, are not subject to appellate review. Commonwealth Coatings Corp. v. Continental Casualty Co., 393 U.S. 145, 149 (1968).

The district court noted that, although Part B hearing officers have not personally participated at earlier stages of the claims they are reviewing, the carrier itself has not only participated in those stages but has twice denied the same claims. (Jur. St., App. A at 9a.)[8/]

[8/] Appellant notes that the prior involvement is by another carrier employee rather than the carrier itself. (Jur. St. 12, 13.) However, these employees are charged with performing their duties pursuant to the instructions that they receive

The court found that since the hearing officers are appointed and serve at the will of the carrier, the hearing officers are tainted by vicarious prior involvement. (Jur. St., App. A, 9a, 10a.) Here, unlike situations where the standards governing an initial determination differ from those governing the subsequent outcome, Part B hearing officers are in fact called on to review the correctness of the carrier's denial of the claim. (Jur. St., App. A, 9a.)

8/ (cont.)
from the carrier, so that a consideration of the policies and practices of the carrier will be closely interrelated with the specific conduct of another employee in any given instance. Carrier policies and interpretations rather than, for example, a clerical error of an employee processing claims, may well be the central issue of the hearing.

That prior involvement of this kind raises the specter of partiality has long been recognized in the context of our courts. Consonant with the long-standing admonitions of the Canons of Judicial Ethics, 28 U.S.C. §455(a), enacted in 1974, requires that a justice, judge or magistrate of the United States "shall disqualify himself in any proceeding in which his impartiality might reasonably be questioned." Heeding this admonition many judges routinely disqualify themselves from any matters in which their former law office is involved, whether or not the particular matter was pending before the judge left the firm. (Jur. St., App. A at 10a,)[9/]

[9/] Appellants attempt to distinguish the present situation from the practice of judges with respect to their law firms by asserting that carriers and their employees

In accord with this legal standard, the Court has repeatedly observed that justice requires the appearance of justice. Marshall v. Jerrico, 446 U.S. 238, 243 (1980), quoting Offutt v. United States, 348 U.S. 11, 14 (1954). See also In re Murchison, 349 U.S. 133, 136 (1955).

Thus the district court was clearly justified in concluding:

9/ (cont.)

are not "advocates". (Jur. St. at 13, n. 8.) This assertion is not supported by the record. In addition, however, the principles stated in 28 U.S.C. §455(a) and previous opinions of this Court go far beyond situations in which questions of partiality arise from former advocacy of the judge. The practice of judges disqualifying themselves from cases accepted by their former firms after they left shows their recognition of the danger of bias resulting from prior involvement, and refutes appellant's other contention that judges disqualify themselves because of "pecuniary or professional interest" in the success of a particular case. (Jur. St. at 13, n.8)

> "To apply appreciably more lax standards to hearing officers whose final decisions, unlike those of most judges, are appealable to no other tribunal, poses a constitutionally-unacceptable risk of decisions tainted by bias." (Jur. St., App. A, 10a.)

The district court's conclusion about the presence of partiality has been echoed in a report and recommendations from the American Bar Association House of Delegates, adopted August 6, 1980. In calling for changes in the Part B hearing procedures, the resolution noted:

> "The only review of adverse determinations by carriers regarding Part B claims that is prescribed under the Medicare Act is the so-called 'fair hearing' required to be offered by carriers with respect to controversies involving amounts in dispute of $100 or more. 42 U.S.C. §1395u(b)(3)(C). As a practical matter, under the current procedure there can be no truly 'fair' hearing since the hearing officer is engaged by the carrier who rendered the initial adverse determination. Under these circumstances, it

> is unreasonable to expect the hearing officer to be impartial."

For the full text, see [1980 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶30,608.

In the words of Justice Harlan, in a concurring opinion in Mayberry v. Pennsylvania, 400 U.S. 455, 469 (1971), "the appearance of even-handed justice . . . is at the core of due process." It is therefore quite significant that a professional association with members who are familiar with the daily workings of the Part B hearing system has challenged its impartiality.

In addition, the uncontested record indicates that there are no specific criteria for selection of hearing officers and that virtually no training is given except by the carriers whose decisions were being reviewed. The district court found that all these factors together

contravened the constitutional requirements of impartiality. (Jur. St., App. A at 11a.)

The presence of these factors is underscored by the fact that five out of the seven hearing officers appointed by defendant Blue Shield of California are former or current Blue Shield employees. While this combination of adjudicatory and other functions, without more, does not constitute a due process violation, Withrow v. Larkin, 421 U.S. 35 (1975), it clearly adds to the other indications of the appearance and probability of bias.

In addition to bias by prior association, the court held that hearing officers have a pecuniary interest in currying the carrier's favor, since the carrier could reduce their future income by calling on them less often or not at all. The presence of a pecuniary interest is not limited to situations in which the

adjudicator's income is tied to the result of the hearing. See Ward v. Village of Monroeville, supra, 409 U.S. 57, 60.

This problem of pecuniary interest can only be heightened by the fact that the carrier has no appeal from the hearing officer's decision. Thus, if the carrier disagrees with a decision, does not want the same principle of decision to be adhered to in the future, and cannot persuade the hearing officer to reverse himself, the carrier has essentially no choice but to terminate the hearing officer.[10/]

[10/] In the Jurisdictional Statement, at 12-13, appellant argues that the district court's findings were insufficient to overcome what he perceives to be a heavy presumption of honesty and integrity applicable to Part B hearing officers. However, the Court has never applied a presumption of integrity to private persons reviewing the decisions of their employers, when the employees have

C. THE RENDERING OF FINAL, UNREVIEWABLE DECISIONS ON MEDICARE CLAIMS BY INSURANCE COMPANY HEARING OFFICERS IS AN UNCONSTITUTIONAL DELEGATION OF THE JUDICIAL POWER OF THE UNITED STATES

10/ (cont.)

no protection against retaliation. Cf. Withrow v. Larkin, supra, 421 U.S. 35, 47, where the decision-makers were public officials.

Appellant also argues (Jur. St., 14-15) that reversal rate statistics refute any affirmative indications of bias. However, the Court has observed that "[b]are statistics rarely provide a satisfactory measure of the fairness of a decision-making process." Mathews v. Eldridge, 424 U.S. 319, 346 (1976). In this case, the district court carefully evaluated these statistics and found them to be entitled to little, if any probative value. For example, the term "reversal" included either complete reversals or partial reversals which might be modifications of a claim based on disclosure of a small computer coding error. Indeed, there was ample evidence in the record that over

The second basis for the district court's decision was its holding that the unavailability of any independent, administrative review of carrier-appointed hearing officers' decisions represents an

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10/ (cont.)

95% of the "reversals" recorded by defendant Blue Shield of California were actually partial reversals, and also that there was an alarmingly high rate of computer coding errors made in initial claims processing. Thus, the district court's conclusion that the reversal rate statistics tell little about the hearing officers' willingness to disagree with the substantive decisions of the carriers is obviously correct. (Jur. St., App. A, 13a.)

Further, appellant argues that it is unlikely that a single carrier hearing officer's decision will cause termination of the carriers' contract, and therefore, that it is unlikely that the hearing officer will be deterred from reaching the correct result. (Jur. St., 14, 16.) However, a disagreement between the hearing officer and the carrier as to whether the carrier is fulfilling its contract with H.H.S. to properly process claims can be embarrassing to the carrier. Furthermore, the hearing officer has no protection against retaliation, and the carrier has no appeal to vindicate itself.

unconstitutional delegation of the judicial power, in violation of Article III, Section 1 of the Constitution.11/ The court analyzed this issue by considering whether due process guarantees required additional protections. Thus, in the district court's view, the presence of an unlawful delegation depended on whether due process was violated by the current system. See Wright, Miller and Cooper, Federal Practice and Procedure, Jurisdiction §3526, (West, 1975).

10/ (cont.)

Finally, carriers are under constant pressure from H.H.S. to conserve funds by denying claims, a goal which is frustrated when hearing officers reverse the denials. (Plaintiffs' Memorandum in Support of Motion for Summary Judgment, pp. 23-27.)

Thus, "under a realistic appraisal of psychological tendencies and human weakness," Withrow v. Larkin, 421 U.S. 35, 47, a serious risk of bias is presented.

11/ See page 26.

The district court applied the test set forth by this Court in Mathews v. Eldridge, 424 U.S. 319, 335, (1976), to determine the dictates of due process, which requires evaluation of three factors:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

First, the court noted that the private interest at stake, a Medicare beneficiary's right to reimbursement, is sufficiently important to invoke the Due Process Clause,

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11/ St. Louis University v. Blue Cross Hospital Service, 537 F.2d 283, 293, (8th Cir. 1976), Cert. Denied, 429 U.S. 977 (1976); Ass'n. of American Physicians & Surgeons v. Weinberger, 395 F. Supp. 125 140, (N.D. Ill. 1975).

and that the denial of that right may impose considerable hardship. (Jur. St., App. A, 13a.)[12/]

Secondly, the district court considered the risk of erroneous deprivation of benefits and the value of additional procedures. It discounted the probative value of appellant's reversal rate statistics, as did the Court in Mathews v. Eldridge, supra. See n. 9, supra. In view of the close interrelationship between the impartiality and delegation issues (Jur. St., App. A, 8a,) and since the hearing officers were acting with unreviewable authority without satisfying any threshold selection criteria

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12/ Appellants apparently do not dispute the court's evaluation of the first factor. Rather, they assert that it weighs heavily against the district court's conclusion, rather than in favor of it. (Jur. St., 18-19, 21-22.)

such as knowledge of the law, the district court was clearly justified in finding that additional safeguards would be of value.

Indeed, "a purpose of procedural due process is to convey to the individual a feeling that the government has dealt with him fairly, as well as to minimize the risk of mistaken deprivations of protected interests." Carey v. Piphus, 435 U.S. 247, 262 (1978). Thus, the value of additional safeguards, in addition to reducing error in claims determinations, is evident because it provides Medicare recipients some opportunity for redress of their grievances against carrier decisions with the government agency whose function it is to oversee the carrier.

Thirdly, the district court considered the cost element by noting that the

Social Security Administration already has an existing procedure for governmental review of insurance company decisions under Part A of the Medicare program, so that providing a further review of carrier hearing officer decisions "would not require the creation of a new appeals system or a new bureaucracy." (Jur. St., App. A., 14a.) Although the court could not determine in advance how many additional hearings would be requested, it noted that there was no indication that the additional procedures would prove costly, since "only a fraction of those claimants pursue their currently available remedies."[13/] (Jur. St., App. A, 14 a, and App. F, 39a.)

13/ In the period between the court's judgment dated May 1, 1981 and Justice Rehnquist's issuance of a stay on June 12, 1981, Part B hearing officer decisions were accompanied with a notice of a right to appeal. The appellants have not tabulated

Thus, considering the three governing factors, the district cour. properly concluded that the existing Part B hearing procedure did not comport with due process. (Jur. St., App. A, 14a, 15a.) Thereupon, the court directed the Secretary to prepare a plan to implement the court's decision. (Jur. St., App. A, 21a-22a.)

D. THE REMEDY ORDERED BY THE COURT WAS THE SIMPLEST AND MOST EQUITABLE POSSIBLE.

The Secretary's plan, contained in the affidavit of Daniel L. Skoler (see Jur. St. 10, n.5) provided that the Social Security Administration's Office of Hearings and

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13/ (cont.)
the response of the beneficiaries who received these notices, so there is at present no evidence to support their prediction (Jur. St. 21,) that thousands of cases will be added to the docket of ALJ's each year.

Appeals would assume responsibility for reviewing carrier decisions by providing an attorney, independent of the carrier, to conduct an evidentiary hearing on the request of a beneficiary dissatisfied with the carrier hearing officer decision denying his claim.[14/]

The district court in its order filed April 9, 1981 (Jur. St., App. C, 24a-30a) and the judgment filed May 1, 1981 (Jur. St., App. E, 34a-37a) adopted the broad outlines of the Secretary's proposal for hearings to be administered by the Office of Hearings and Appeals.

14/ Appellant's plan would have created a new beaurocracy within the Office of Hearings and Appeals to provide hearings by lawyers rather than ALJ's.

In stating that due process does not require that an administrative hearing be conducted by a lawyer (Jur. St. at 20), appellant does not mention that he himself proposed reviews by lawyers.

However, the district court declined to authorize a new bureaucracy within that organization to provide hearings with a new hearing corps to hold hearings only on Part B claims. Rather, the court left the Part B hearing system intact and ordered that a subsequent level of appeals to de novo hearings before ALJ's be made available.

The district court's order was clearly correct, inasmuch as a new bureaucracy, created by court order, could entail extensive judicial supervision. Unlike the existing hearing officer corps which handles Part A cases, a new corps would be a non-statutory establishment totally foreign to the Medicare system. This Court has rejected such "judicial legislation" in the formulation of relief. Califano v. Westcott, 443 U.S. 76 (1979).

Furthermore, there was no evidence that the number of appeals would be sufficiently large to justify a new bureaucracy to deal with it, and the attendant costs.[15/]

The Secretary's disagreement with the court's remedy, thus, presents the narrow issue of whether the court properly exercised its broad discretion in ordering a simple appeal process rather than the establishment of a unique, new federal hearing system.

[15/] The fact that the judgment indicates reluctance concerning judicial creation of a new bureaucracy and corps of hearing officers does not preclude Congress from appropriate remedial legislation consistent with due process guarantees.

CONCLUSION

For the foregoing reasons, the Court should affirm the judgment below without argument or further briefing.

Respectfully submitted,

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Appellant's Brief

FILED
DEC 8 1981
ALEXANDER L. STEVAS,
CLERK

No. 81-212

In the Supreme Court of the United States

OCTOBER TERM, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

WILLIAM MCCLURE, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

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QUESTION PRESENTED

Whether 42 U.S.C. 1395u(b)(3)(C), which provides that hearings on disputed claims for payment of medical expenses under Part B of Title XVIII of the Social Security Act (commonly referred to as the Medicare program) are to be conducted by private insurance carriers, violates the due process rights of Medicare claimants because it does not provide for a hearing before an Administrative Law Judge in the Department of Health and Human Services.

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In the Supreme Court of the United States

OCTOBER TERM, 1981

No. 81-212

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

WILLIAM MCCLURE, ET AL.*

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

BRIEF FOR THE APPELLANT

OPINION BELOW

The opinion of the district court (J.S. App. 1a-19a) is reported at 503 F. Supp. 409.

JURISDICTION

The final judgment of the district court was entered on the Court's docket on May 5, 1981 (J.S. App. 34a-37a), and the Secretary filed a notice of appeal on that date. J.S. App. 41a-43a. The district court apparently determined that it had jurisdiction of the case under 28 U.S.C. 1331 or 1361. See J.S. 22 n.16. On June 26, 1981, Justice Rehnquist extended the time within which to docket the appeal to and including August 1, 1981, and the jurisdictional statement was filed on July 31,

* Blue Shield of California also was named as a defendant in the district court. The named plaintiffs are William McClure, Charles Shields, and "Ann Doe," who represent a class of all beneficiaries of the Part B Medicare Program who have received a decision of a carrier hearing officer dated on or after May 1, 1980, in which a request for payment of benefits has been denied in whole or in part and in which the amount remaining in controversy after the carrier hearing officer's decision is at least $100.

1981. The Court noted probable jurisdiction on October 13, 1981. J.A. 62. The jurisdiction of this Court is invoked under 28 U.S.C. 1252.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

1. The Fifth Amendment to the United States Constitution provides in pertinent part:

> No person shall * * * be deprived of life, liberty, or property, without due process of law * * *.

2. Pertinent portions of Section 1842 of the Social Security Act, 42 U.S.C. 1395u, are reprinted as an appendix to this brief, *infra*, 1a-6a.

STATEMENT

1. Title XVIII of the Social Security Act, commonly known as the Medicare program, is divided into two parts. Part A provides insurance for hospital and related post-hospital services. 42 U.S.C. (& Supp. III) 1395c to 1395i-2. Part B provides a voluntary program of supplementary medical insurance covering, in general, 80% of the reasonable charges for certain other services—primarily physicians' services and such items as medical supplies, x-rays, and laboratory tests. 42 U.S.C. (& Supp. III) 1395k, 1395*l* and 1395x(s). This case involves a challenge to the statutory provision for evidentiary hearings on reimbursement claims under Part B of the Medicare program.

Benefits under Part B are financed out of the Federal Supplementary Medical Insurance Trust Fund established in the Treasury. 42 U.S.C. (& Supp. III) 1395a and 1395g. This Trust Fund is supported by appropriations from the Treasury and by premiums paid by those persons who are 65 or older or disabled and who choose to enroll in the Part B program. 42 U.S.C. (& Supp. III) 1395c, 1395f and 1395w; *see Mathews* v. *Diaz*, 426 U.S. 67, 70 n.1 (1976).

The Secretary of Health and Human Services is responsible for determining whether an individual is eligible to enroll and has enrolled in the Part B program.

42 U.S.C. 1395o, 1395p and 1395ff(a). If the beneficiary is dissatisfied with the Secretary's determination, he is entitled to an administrative hearing by the Secretary and to judicial review of the Secretary's final decision after the hearing. 42 U.S.C. 1395ff(b)(1)(B).

The Secretary of HHS does not, however, review individual medical reimbursement claims filed by or on behalf of persons who are enrolled in the Part B program. Instead, Congress authorized the Secretary to enter into contracts with private insurance carriers[1] under which the carriers determine and pay Part B claims on his behalf. 42 U.S.C. 1395u(a)(1)(A) and (B). Pursuant to these contracts, the carriers receive advances of funds from the Supplementary Medical Insurance Trust Fund (42 U.S.C. 1395u(c)), which they then disburse to claimants in reimbursement for medical services found by the carriers to be covered by Part B. *See* 42 U.S.C. 1395u(a)(1)(A), 1395u(b)(3)(A) and (B), 1395u(c). The contracts also require the federal government to reimburse the carriers for their neecssary and proper costs of determining and paying claims. 42 U.S.C. 1395u(c).

A claim for reimbursement may be submitted to the carrier either by the beneficiary or by the physician or other person who furnished the services, if the beneficiary has assigned his reimbursement claim to that person. 42 U.S.C. 1395u(b)(3)(B); 42 C.F.R. 405.801(a) and 405.802(b).[2] The carrier must make an initial

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[1] The term "carrier" is defined in 42 U.S.C. 1395u(f).

[2] The Secretary has provided by regulation that the assignee of a Part B claim shall have the same procedural rights as the beneficiary from whom he has accepted an assignment. 42 C.F.R. 405.801(a).

If the services were furnished by a hospital, skilled nursing facility, or similar entity, the Act provides that reimbursement *must* be made directly to the entity that furnished the services, rather than to the beneficiary. 42 U.S.C. (& Supp. III) 1395k(a)(2) and 1395n. In these situations, the reimbursement is made on the basis of the reasonable *cost* to the hospital or other entity for the services, not the reasonable *charge* that would be made to the patient, as in the case of other services covered by Part B. See page 47 & note 42, *infra*. For convenience, we shall discuss

determination whether the services for which payment is sought were medically necessary and are otherwise covered by Part B and, if so, whether the charge for the services is reasonable. 42 C.F.R. 405.803(b); see 42 U.S.C. (& Supp. III) 1395u(a)(1)(A), 1395u(b)(3) and 1395y(a). If the claimant is dissatisfied with the initial determination of the claim, he has a right to have it reviewed by an employee of the carrier other than the employee who made the initial determination.

In addition, the Act requires the carrier to "establish and maintain procedures pursuant to which an individual enrolled under [Part B] will be granted an opportunity for a fair hearing by the carrier" if his request for payment has been denied or the amount of reimbursement due is in dispute and the amount in controversy is $100 or more. 42 U.S.C. 1395u(b)(3)(C). The statutory "fair hearing" is conducted by a hearing officer designated by the carrier (42 C.F.R. 405.823) who has not participated personally in any prior review of the claim. 42 C.F.R. 405.824; J.S. App. 9a. The hearing officer examines witnesses at the hearing, and the claimant also is entitled to submit additional documents, examine witnesses, and present argument. 42 C.F.R. 405.830. The hearing officer's decision must be based on the record of the hearing and must be supported by findings of fact and a statement of reasons. 42 C.F.R. 405.834. The decision by the carrier's hearing officer is final and binding upon the claimant (42 C.F.R. 405.835), and there is no right under the Act to a further administrative hearing by the Secretary or to judicial review of the hearing officer's decision.

2. The instant case is a nationwide class action brought in the United States District Court for the Northern District of California challenging the constitutionality of the Medicare Part B hearing procedures. The district court certified a class of all persons who have received decisions from carrier hearing officers dated on or after

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in this brief only those situations in which reimbursement is made to the beneficiary or his assignee on a reasonable charge basis.

May 1, 1980, in which a claim for reimbursement under Part B has been denied in whole or in part and in which the amount remaining in controversy after the statutory "fair hearing" is $100 or more. J.S. App. 27a, 29a, 35a, 37a.[3]

On cross-motions for summary judgment (J.S. App. 20a), the district court held that 42 U.S.C. 1395u(b)(3)(C) is unconstitutional under the Due Process Clause of the Fifth Amendment because it provides for a final determination of Medicare Part B claims to be made by a hearing officer designated by the carrier, rather than by the Secretary. The court therefore concluded that any person whose Part B reimbursement claim was denied by the carrier following a hearing must be afforded the right to a de novo evidentiary hearing on the claim before an Administrative Law Judge (ALJ) in the Department of Health and Human Services (HHS). J.S. App. 8a-16a, 18a-19a, 21a-22a, 24a, 27a, 29a, 36a. The court relied on two different lines of reasoning:

a. The district court first concluded that 42 U.S.C. 1395u(b)(3)(C) violates the Due Process Clause because, in the court's view, a hearing officer appointed by the carrier is *not* an impartial decision-maker. J.S. App. 8a-11a. The court acknowledged (*id.* at 9a) that the hearing officer does not participate personally in the

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[3] There were three named plaintiffs. Plaintiff McClure was denied partial reimbursement for the cost of an air ambulance that transported him to a hospital specially equipped to treat his myocardial infarction; the hearing officer ruled that although the ambulance services were medically necessary, McClure should have been taken to a suitably equipped hospital that was closer to his home. Plaintiff Shield was denied reimbursement for part of the cost of an operation that involved both a cholecystectomy and an appendectomy; the hearing officer concluded that the appendectomy was merely incidental to the cholecystectomy and disallowed that portion of the claim that was attributable to the former. Plaintiff "Ann Doe" was denied reimbursement under Part B for a sex change operation on the ground that it was not a covered medical service. See J.S. App. 2a-4a; see also Affidavit of Stanley Katz, ¶ 5 (J.A. 12).

case prior to the hearing. Nevertheless, the court concluded (*ibid.*) that the officer has been "vicariously involved" in the case because he has been appointed by a carrier that has twice denied the same claim. This, the court concluded, "poses a constitutionally-unacceptable risk of decisions tainted by bias" (*id.* at 10a).

The court found this risk of bias "heightened" by what it perceived to be the hearing officer's "pecuniary interest in currying the carrier's favor" (J.S. App. 10a). The court acknowledged (*ibid.*) that the expense of the hearing officer's salary is reimbursed by the federal government and therefore is not borne by the carrier. The court concluded (*ibid.*), however, that the hearing officer has a pecuniary interest in the hearing because his income is dependent upon the carrier's decision regarding whether, and how often, to call upon his services.

The court also perceived additional "indicia of potential bias" in the fact that hearing officers are trained principally by the carrier, except for occasional training sessions conducted by HHS, and the fact that the Secretary does not mandate "specific" criteria for the selection of a hearing officer, beyond the requirements in HHS's Carriers Manual that he be an attorney or other person qualified to conduct formal hearings and be knowledgeable about medical matters and the Medicare program. J.S. App. 11a; see page 19, *infra*. Although the court conceded that each of the various factors it considered might not in itself contravene the constitutional requirement of impartiality, the court nonetheless held that "their combined effect is constitutionally impermissible" (J.S. App. 11a).

b. In addition to concluding that a hearing conducted by the carrier poses a risk of bias, the district court held (J.S. App. 12a-16a) that appellees in any event have a due process right to a hearing conducted by the Secretary. The court believed this result to be supported by a consideration of the three-part test announced in *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976):

First, in weighing the private interest at stake, the the court acknowledged (J.S. App. 13a) that the claimant's interest in receiving reimbursement under Part B of the Medicare program for particular medical services is less substantial than the right to receive welfare or social security benefits.[4] This is so, the court reasoned, because Medicare benefits are not based on financial need, because Part B covers only supplementary rather than primary medical services, and because the denial of a particular claim does not deprive the beneficiary of the right to receive reimbursement for other covered services. Nevertheless, the district court concluded (*ibid.*) that a denial of reimbursement for particular services "may impose considerable hardship" to the individual.

Second, the court found the record "inconclusive" (J.S. App. 13a) on whether the provision in 42 U.S.C 1395u(b)(3)(C) for a "fair hearing" by the carrier poses a high risk of an erroneous deprivation of Medicare benefits. The court referred to statistics showing that carrier hearing officers reversed the carrier's previous determination in whole or in part in nearly half of the cases, but it declined to rely on these data as demonstrating that the carriers' hearing officers give close and fair scrutiny to individual claims, because the figures did not indicate the extent or significance of "partial" rather than "total" reversals or the breakdown between "technical" and "substantive" reversals. *Ibid.* Having rejected these data, however, the district court cited no evidence affirmatively showing that there *is* a high risk of error under the current system of carrier-conducted hearings. Instead, because of what it perceived to be insufficient formal training of carrier hearing officers by HHS and the absence of a requirement that they meet specific threshold eligibility criteria such as having a law degree, the court simply "assumed that additional safeguards [*i.e.*, hearings by the Secretary] would reduce the

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[4] Welfare and social security benefits were at issue in *Goldberg* v. *Kelly*, 397 U.S. 254 (1970), and *Califano* v. *Yamasaki*, 442 U.S. 682 (1979), to which the district court contrasted the instant case. J.S. App. 13a.

risk of erroneous deprivation of Part B benefits" (*id.* at 13a-14a).

Third, although the district court recognized that "[t]he government clearly has a strong interest in controlling the costs associated with the Part B Medicare program" (J.S. App. 14a) and that more than 124 million Part B claims were processed in 1978 (*ibid.*), the court concluded that a second round of evidentiary hearings conducted by ALJs in HHS would not be unduly costly. The court reasoned (*ibid.*) that not all claimants who requested a "fair hearing" by the carrier would request a second evidentiary hearing by an ALJ in HHS and that it would not be necessary to create a "new bureaucracy" to conduct such hearings because ALJs in HHS already were conducting hearings on certain claims arising under Part A of the Medicare Act. Thus, the court concluded, its holding "would simply increase the number of claimants who utilize the existing Part A administrative appeal" (*ibid.*).[5]

c. The district court's final judgment, entered on May 5, 1981, requires the Secretary to take all necessary action to ensure that persons whose Part B claims were denied in whole or in part by a carrier hearing officer after May 1, 1980 are afforded the right to an administrative appeal in the form of a de novo hearing before an ALJ in HHS, if the amount remaining in controversy after the carrier hearing is at least $100. J.S. App. 36a-37a.[6] The district court denied the Secre-

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[5] The court rejected appellees' contentions that the Due Process Clause requires the use of a preponderance of the evidence, rather than substantial evidence, standard in Part B hearings and that "great weight" must be attached to medical evidence. J.S. App. 16a-17a. The court also held that the difference in procedures available in reviewing claims for benefits under Parts A and B of the Medicare Act does not violate the equal protection guarantee of the Due Process Clause. *Id.* at 17a-18a. Nevertheless, in its final judgment, the court required Part A procedures to be applied in ALJ hearings on Part B claims. *Id.* at 36a.

[6] In so ordering, the district court rejected the Secretary's proposal that experienced attorney-advisors in the Social Security Administration's Office of Hearings and Appeals, rather than ALJs,

tary's motion for a stay pending direct appeal of its decision to this Court. J.S. App. 38a-40a However, on June 12, 1981, Justice Rehnquist issued an order staying the district court's judgment pending this Court's disposition of the appeal. No. A-961, 1980 Term; J.S. App. 44a-48a.

INTRODUCTION AND SUMMARY OF ARGUMENT

The district court has held unconstitutional the hearing procedures established by Congress to resolve claims under one of the largest and most complex federal social welfare programs. There now are more than 27 million aged and disabled participants in the voluntary program of supplementary medical insurance under Part B of the Medicare Act, and more than $10 billion in benefits are paid out annually under that program.[7] The day-to-day administration of the insurance program requires the determination of a vast number of requests for payment of individual bills for doctors' visits and such items as medical supplies, x-rays, and laboratory tests. The district court noted (J.S. App. 14a) that more than 124 million such claims were processed in 1978 alone, and the number of claims increased to 158 million in 1980. See Health Care Financing Administration *Report*, note 42, *infra*, Table A.

As we explain below, when Congress enacted the Medicare Act in 1965, it concluded that an insurance program of this dimension and complexity could be administered most efficiently and conveniently by private insurance carriers, which already were experienced in determining whether physicians' and other services are medically

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conduct the Part B hearings that the court ordered to be conducted by the Secretary. The Secretary's proposal, which was based on the fact that ALJs in HHS were already severely overburdened with an expanding caseload of hearings, was submitted in the form of an October 18, 1980 affidavit of Daniel L. Skoler, Deputy Associate Commissioner for the Office of Hearings and Appeals of the Social Security Administration.

[7] See *1981 Annual Report of the Federal Supplementary Medical Insurance Trust Fund*, H.R. Doc. No. 97-68, 97th Cong., 1st Sess. 2, 21 (1981).

necessary and in calculating the reasonable charge for such services. Consistent with this judgment, Congress concluded that evidentiary hearings on disputed Part B claims should be conducted by the expert carriers in which it had entrusted other aspects of the administration of the Part B Medicare program.

Congress' legislative judgment that the carriers' review of claims would be impartial and would afford appropriate procedural protections is reflected in the text of 42 U.S.C. 1395u(b)(3)(C), the statutory provision that the district court held unconstitutional. Section 1395u(b)(3)(C) directs the Secretary to ensure that his contracts with the carriers require them to "establish and maintain procedures" under which beneficiaries would be granted an opportunity for a "*fair hearing*" (emphasis added). The Secretary has implemented this requirement through detailed regulations and instructions to the carriers designed to ensure the fairness and integrity of the evidentiary hearings conducted by the carriers. Congress also concluded that further review of individual claims by the Secretary or the courts is not warranted, especially in view of the relatively small amount of money involved in the typical Part B claim.

The decision of the district court disregards this considered judgment of Congress and instead rewrites the statute to require the Secretary to conduct a second evidentiary hearing on a claim after the carrier has conducted a "fair hearing" and denied the claim. Only the most convincing demonstration of the inadequacy of the carrier hearing process established by Congress and the Secretary could support such a holding. Yet the district court did not point to any evidence drawn from the accumulated experience of carrier-conducted hearings in scores of thousands of cases since 1965 to demonstrate that Congress and the Secretary were wrong in concluding that carriers could be relied upon to conduct appropriate hearings consistent with the due process requirement of "fundamental fairness" (*Lassiter* v. *Department of Social Services*, No. 79-6423 (June 1, 1981), slip op. 5)). Rather, the district court held 42 U.S.C.

1395u(b)(3)(C) unconstitutional solely on the basis of unsupported speculation that carrier hearing officers might not be partial and that ALJ hearings in HHS might reduce the risk of erroneous decisions. But the congressional plan deserved far greater deference, and the court therefore should "not [have] presume[d] on this record to say that it works unfairly" (*Richardson* v. *Perales*, 402 U.S. 389, 403 (1971)).

The district court's expressed misgivings about the Part B hearing procedures are, at bottom, nothing more than a disagreement with Congress' policy decision to entrust the details of administration of the supplementary insurance program to private insurance carriers under government supervision, rather than to a government agency. Moreover, by imposing the district court's own view of the preferable administrative procedure for resolving Part B reimbursement disputes—hearings conducted by ALJs in HHS—the decision below would severely strain the corps of administrative law judges, who already are overburdened with hearing requests in cases arising under other sections of the Social Security Act and other statutes in which *Congress* has provided for hearings by the Secretary.

The procedures the carriers must follow in conducting the statutory "fair hearing" ensure that a Part B claimant will have a meaningful opportunity to be heard. If a claimant is dissatisfied with the carrier's initial determination and subsequent file review of his request for reimbursement, he has a statutory right under 42 U.S.C. 1395u(b)(3)(C) to a "fair hearing" if the amount remaining in controversy is $100 or more. The hearing must be conducted by an attorney (or other person qualified to conduct formal hearings) who has had no prior involvement in reviewing the claim. The Secretary's instructions further provide that the hearing officer must have a general understanding of medical matters and terminology and a thorough knowledge of the Medicare program, and must render independent and impartial decisions. At the hearing itself, the hearing officer may examine witnesses, and the claimant has a right to ex-

amine witnesses, submit other evidence, and present argument. Although the hearing officer's decision on an individual claim is final and binding, the Secretary periodically reviews a sample of hearings conducted by all carrier hearing officers in order to ensure a uniform application of these due process principles.

II

A. The district court's conclusion that a hearing officer appointed by the carrier cannot be regarded as an impartial decision-maker is without merit. The expense of the hearing officer's salary and the amount of any claim he finds to be meritorious is borne by the federal government, not the carrier. Accordingly, neither the hearing officer nor the carrier has a financial interest in the outcome of a case. Nor is there any reason to believe that a hearing officer would seek to curry favor with the carrier by denying a claim, in hopes that he would be retained by the carrier to preside at hearings in the future. To the contrary, the carrier's contract with the Secretary obligates it to pay meritorious claims, and a hearing officer seeking to maintain the favor of the carrier would fulfill this obligation.

There likewise is no merit to the district court's conclusion that the hearing officer's impartiality is tainted by a "vicarious involvement" in the case because he reviews a claim that employees of the carrier previously have denied. The carrier and its employees and hearing officers all act as agents of the Secretary, in the same manner as ALJs and employees in HHS who adjudicate claims arising under other provisions of the Social Security Act. Accordingly, just as the Due Process Clause does not bar one employee in a government agency from reviewing a matter that another agency employee has previously determined, a carrier hearing officer is not barred from considering a claim that other employees of the carrier have reviewed.

The district court also erred in relying upon the rule of judicial conduct requiring a judge to disqualify himself if a lawyer with whom he previously practiced law served during their association as a lawyer concerning

the matter. See 28 U.S.C. 455(b)(2). That rule applies where the judge and the lawyer served together as *advocates*, not *adjudicators*, as in the present case.

B. The district court erroneously concluded that Part B claimants have a due process right to a hearing by the Secretary because such a hearing might be more reliable. The court cited no evidence for this proposition; the court simply "assumed" it to be true, principally because ALJs, unlike carrier hearing officers, must be lawyers. But the *relative* qualifications of carrier hearing officers and ALJs in HHS are irrelevant. The relevant inquiry is whether carrier hearing officers meet the *absolute* standards of minimum competence required by the Due Process Clause. This Court has held that the person who presides at an administrative hearing need not be a lawyer, and there is no basis in the present record for concluding that carrier hearing officers are insufficiently qualified or trained in any other respect. But even if the record supported such a finding, the appropriate remedy would be to order that the carriers appoint hearing officers who are more "qualified," not to restructure the statutory scheme in the manner rejected by Congress.

The district court also misapplied the three-part test in *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976), even assuming it was necessary for the court to weigh the relative qualifications of carrier hearing officers and ALJs. First, the private interest at stake is the claimant's right to reimbursement on an individual claim that is typically small in amount. An adverse decision on this discrete claim does not affect his eligibility to continue to participate in the program generally and to receive Part B benefits in other circumstances. Second, there is no evidence in the record that there is a high risk of erroneous deprivation of benefits in carrier hearings simply because the hearing officers need not be lawyers and do not receive the same training as ALJs in HHS; nor is there any reason to conclude that ALJs, who have no experience in reviewing Part B claims, would conduct more reliable hearings. And third, the require-

ment that ALJs in HHS conduct Part B hearings that duplicate the statutory "fair hearing" by the carrier would pose a substantial and unwarranted administrative burden on the already overburdened corps of administrative law judges in HHS.

ARGUMENT

42 U.S.C. 1395u(b)(3)(C) DOES NOT VIOLATE THE DUE PROCESS CLAUSE OF THE FIFTH AMENDMENT

I. THE PROCEDURES ADOPTED BY CONGRESS AND THE SECRETARY UNDER PART B OF THE MEDICARE PROGRAM ENSURE THAT CLAIMANTS HAVE A FULL OPPORTUNITY TO BE HEARD IN A "FAIR HEARING" CONDUCTED BY AN IMPARTIAL HEARING OFFICER

A. Congress Chose to Utilize Private Insurance Carriers as Agents of the Secretary Under Part B Because of Their Expertise in Administering Similar Insurance Plans

When Congress enacted Part B of Title XVIII of the Social Security Act in 1965, it concluded that processing and payment of the millions of individual reimbursement claims submitted each year by or on behalf of participants in the supplementary medical insurance program could be undertaken most effectively by insurance carriers which had acquired considerable expertise in administering similar insurance plans in the private sector. S. Rep. No. 404, 89th Cong., 1st Sess. 53 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 46 (1965).[8] Accordingly, for the express purpose of "provid[ing] for the administration of the benefits under [Part B] with maximum efficiency and convenience for individuals entitled to benefits * * *

[8] Congress found "[t]his form of administration * * * particularly appropriate" because of the "great experience" of private insurance carriers in reimbursing physicians (H.R. Rep. No. 213, *supra*, at 46), the principal component of the Part B program. But Congress likewise intended that the carriers' "[a]dministration of other benefits under part B would be handled as is found most efficient and convenient to beneficiaries and persons providing health services" (S. Rep. No. 404, *supra*, at 53).

and for * * * persons furnishing services to such individual[s]" (42 U.S.C. 1395u(a)), Congress authorized the Secretary to enter into contracts with private insurance carriers under which the carriers would determine and pay reimbursement claims submitted under Part B. *Ibid.* Under this arrangement, both the beneficiaries and the physicians and other persons who furnish services to beneficiaries could continue their familiar and convenient practice under private insurance plans of submitting claims to, and resolving reimbursement disputes with, private insurance carriers, rather than a new governmental bureaucracy.

This arrangement also produces efficiencies in the administration of the program and, where appropriate, consistency with the standards and experience under wholly private insurance plans. For example, the "reasonable charge" for a particular physician's service, on which reimbursement under Part B is based, must take into account both the customary charge made by the physician to his patients generally and the prevailing charge made for similar services by all physicians in the locality. 42 U.S.C. (& Supp. III) 1395(u)(b)(3). The carrier ordinarily would have acquired such data in various localities for purposes of administering its own private plans, and therefore it may readily draw on the data for purposes of paying Part B claims. See, *e.g.*, 42 C.F.R. 405.504(c); see also 42 U.S.C. 1395u(b)(3)(B); 42 C.F.R. 405.502(b) and 405.505; S. Rep. No. 404, *supra*, at 44. Similarly, the carriers may draw on their experience in the private sector in determining whether particular services for which reimbursement is sought were medically necessary and therefore covered by the Medicare program, 42 U.S.C. 1395y(a)(1).

Although Congress chose to rely on the expertise of private insurance carriers, it made clear at the same time that "[i]n the performance of their contractual undertaking, the carriers * * * act on behalf of the Secretary, carrying on for him the governmental administrative responsibilities imposed by the [Act]" (S. Rep.

No. 404, *supra*, at 54).[9] To ensure that the carriers properly discharge their responsibilities as agents of the Secretary, Congress and the Secretary have promulgated standards and procedures for the carriers to follow and have established mechanisms for the review of the carriers' performance.

For example, the Act, implementing regulations,[10] and HHS's Carriers Manual describe in considerable detail the medical services covered by Part B, exclusions from that coverage for certain types of services, the criteria and methodology for the carriers to utilize in determining the "reasonable charge" for covered services, and deductibles and other limitations on the reimbursement paid to the beneficiary or his assignee. See 42 U.S.C. (& Supp. III) 1395k-1395n, 1395u(b), 1395x and 1395y; 42 C.F.R. Part 405, Subparts B, C and E. They also set forth the procedures to be followed by the carriers in considering requests for payment under Part B and in entertaining appeals from the denial of such requests. See 42 U.S.C. 1395u(a)(3)(B) and (C); 42 C.F.R. Part 405, Subpart H; Carriers Manual, Chapter XII.[11]

B. The Act and Implementing Regulations and Instructions of the Secretary Afford Part B Claimants a Meaningful Opportunity to be Heard

"The fundamental requirement of due process is the opportunity to be heard and it is an 'opportunity which

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[9] See also 42 C.F.R. 421.5(b); *Mitchell* v. *Occidental Insurance, Medicare*, 619 F.2d 28, 30 (9th Cir. 1980); *Matranga* v. *Travelers Insurance Co.*, 563 F.2d 677 (5th Cir. 1977); *Peterson* v. *Weinberger*, 508 F.2d 45, 51-52 (5th Cir.), cert. denied, 423 U.S. 830 (1975); *Pine View Gardens, Inc.* v. *Mutual of Omaha Insurance Co.*, 485 F.2d 1073, 1075 (D.C. Cir. 1973); *Kuenstler* v. *Occidental Life Insurance Co.*, 292 F.Supp. 532, 535 (C.D. Cal. 1968).

[10] 42 U.S.C. 1395hh provides that "[t]he Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter."

[11] Chapter XII of the Carriers Manual, entitled "Appeals Process," is included in the record in the district court as Attachment A to the Affidavit of Stanley Katz, *supra* note 3. Pertinent excerpts from Chapter XII of the Carriers Manual are reproduced in the Joint Appendix in this Court. J.A. 15-43.

must be granted at a meaningful time and in a meaningful manner.'" *Parratt* v. *Taylor*, No. 79-1734 (May 18, 1981), slip op. 12, quoting *Armstrong* v. *Manzo*, 380 U.S. 545, 552 (1965). The three-stage review process mandated by the Act and implementing regulations and the Carriers Manual, described below, plainly afford Part B claimants this right.

1. *The Initial Determination*

When a claim is first submitted, the carrier must make an initial determination whether the services for which payment is sought were reasonable and necessary for the diagnosis or treatment of an illness and are otherwise covered by Part B and, if so, whether the deductible has been met and the charge for the services is reasonable. 42 C.F.R. 405.803(b). The carrier must mail a written notice of this determination to the claimant, informing him of his right to have the initial determination reviewed if he is dissatisfied with it. 42 C.F.R. 405.804. If the claimant does not request a review, the initial determination by the carrier is final and binding upon the claimant. 42 C.F.R. 405.806.

2. *The Review Determination*

If a dissatisfied claimant requests a review of the carrier's initial determination, that review must be conducted by an employee of the carrier who was not involved in making the initial determination. J.S. App. 3a; see Carriers Manual § 12010.2(B), J.A. 18. The Carriers Manual explains that "[t]he purpose of the review is to provide a new, independent, and critical examination of the claim." *Id.* at § 12010.2(C), J.A. 18. To this end, the claimant must be given an opportunity to submit additional evidence and contentions of fact or law bearing on the claim, and the carrier is to request further evidence from the beneficiary or the physician or other person who furnished the services to him if necessary for a proper adjudication. 42 C.F.R. 405.809; Carriers Manual § 12010.2(D), J.A. 17. The review determination then is made on the basis of all the evi-

dence in the record. 42 C.F.R. 405.810.[12] The carrier must send the claimant a written statement of the basis for the decision (42 C.F.R. 405.811) and must inform the claimant of his statutory right under 42 U.S.C. 1395(b)(3)(C) to an evidentiary "fair hearing" conducted by the carrier if the amount remaining in controversy on the claim is $100 or more. 42 C.F.R. 405.811.[13] If the claimant does not request an evidentiary hearing, the review determination is final and binding. 42 C.F.R. 405.812; Carriers Manual § 12010.2(G), J.A. 19.

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[12] The Carriers Manual explains that "[s]ince one of the purposes of instituting the review is to reduce unnecessary costs, the review does not provide for a personal appearance or testimony by the claimant." Carriers Manual § 12010.2(E), J.A. 18. In *Gray Panthers* v. *Schweiker*, 652 F.2d 146 (D.C. Cir. 1981), the court held that Part B review procedures do not fully satisfy due process requirements *insofar* as they are applied to persons with claims *of less* than $100, who do not have a statutory right to a subsequent evidentiary hearing. The case is now pending, on remand, in the district court. The *Gray Panthers* holding does not relate to the instant case, because the appellee class here is comprised of persons who had claims with $100 or more remaining in controversy after the record review determination and who therefore were entitled to a full evidentiary hearing.

[13] As originally enacted in 1965, the Act did not require a minimum amount in controversy for the claimant to obtain an evidentiary hearing. See 42 U.S.C. (1970 ed.) 1395u(b)(3)(C). The $100 amount-in-controversy requirement was added in 1972 (Pub. L. No. 92-603, Section 262, 86 Stat. 1448) in order to free the carrier of the burden of holding full evidentiary hearings on exceedingly small claims. See H.R. Rep. No. 92-231, 92d Cong., 1st Sess. 116 (1971); S. Rep. No. 92-1230, 92d Cong., 2d Sess. 213 (1972).

Under HHS regulations, the amount in controversy is the actual amount charged the individual for the items and services, less any amount for which payment has already been made by the carrier and less any applicable deductible and coinsurance amounts. 42 C.F.R. 405.820(b)(1). In order to satisfy the $100 amount-in-controversy requirement, the claimant may aggregate any claims that have been through the review process during the preceding six months. 42 C.F.R. 405.820(b)(2); Carriers Manual § 12010.2(F), J.A. 19.

3. *The Statutory "Fair Hearing"*

A person whose claim has been denied in whole or in part after the carrier's review determination has a statutory right to a "fair hearing" if the amount in controversy remaining after the review determination is at least $100. 42 U.S.C. 1395u(b)(3)(C). The hearing is conducted by a hearing officer, selected by the appropriate official of the carrier (42 C.F.R. 405.824), who has not previously been involved in any way in the determination of the claim. J.S. App. 9a; Carriers Manual § 12016(B), J.A. 22. The Carriers Manual provides that the carrier should designate as a hearing officer "an attorney or other qualified individual with the ability to conduct formal hearings and with a general understanding of medical matters and terminology." In addition, the hearing officer "must have a thorough knowledge of the Medicare program and the statutory authority and regulations upon which it is based, as well as rulings, policy statements, and general instructions pertinent to the Medicare Bureau." And, finally, the Carriers Manual emphasizes that the Hearing Officer "must make independent and impartial decisions, write clear and concise statements of facts and law, secure facts from individuals without causing unnecessary friction, and be objective and free of any influence which might affect impartial judgment as to the facts, while being particularly patient with older persons and those with physical and mental impairments." *Ibid.*

The hearing officer "acquires jurisdiction immediately upon the claimant's filing a request for [a] hearing," at which point the carrier must furnish the hearing officer with all material in its possession pertaining to the claim. Carriers Manual § 12015(A), J.A. 20. The Carriers Manual makes clear that the hearing process is relatively informal and is "nonadversary in nature in that neither the carrier nor the Medicare Bureau is in opposition to the party but is interested only [in] seeing that a proper decision is made." § 12020, J.A. 31-32; see also *id.* at § 12016(B), J.A. 22. Thus, the carrier, like the Social Security Administration with respect to claims

it considers under other titles of the Social Security Act, "operates essentially, and is intended to do so, as an adjudicator and not as an advocate or adversary." *Richardson* v. *Perales*, 402 U.S. 389, 403 (1971). And like an ALJ in the Social Security Administration (*id.* at 408-409), the hearing officer appointed by a Part B carrier is directed to "inquire fully into the matters at issue" (42 C.F.R. 405.830(a)) and to "protect the claimant's rights by making every effort to insure that sufficient evidence is obtained" (Carriers Manual § 12017(C), J.A. 27), rather than to leave the burden entirely on the claimant. This informal and nonadversarial cast to the hearing fulfills the complementary statutory goals that the hearing be "fair" (42 U.S.C. 1395u(b)(3)(C)) and that the administration of benefits generally be accomplished "with maximum efficiency and convenience for individuals entitled to benefits * * * and for * * * persons furnishing services ~~benefits~~ to such individual[s]" (42 U.S.C. 1395u(a)).

In advance of the hearing, the hearing officer must review the record already developed regarding the claim in order to identify areas where evidence is conflicting, inconclusive, or lacking. Following this review, he may request the presence at the hearing of a consultative physician or other expert witness and may obtain additional evidence from the carrier, physician, or other source. Carriers Manual § 12017(C), J.A. 27. Notice of the actual hearing date must be sent to the claimant at least 14 days in advance and must "contain sufficient information about the hearing procedures for the parties to prepare effectively for the hearing." Carriers Manual § 12017(A), J.A. 26. At the hearing itself, the hearing officer may examine witnesses, and the claimant is entitled to produce and examine witnesses, submit additional documentary evidence, and present oral and written argument on issues of law and fact. 42 C.F.R. 405.830(a) and (b); Carriers Manual §§ 12018-12020, J.A. 29-37.[14]

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[14] The Carriers Manual thoroughly explains to the hearing officer his responsibilities in conducting the hearing, covering such matters

A type-written or tape recorded transcript of the hearing must be made. 42 C.F.R. 405.833; Carriers Manual § 12020(F), J.A. 36.

As soon as practicable after the close of the hearing, the hearing officer must issue a written decision. The decision, which is to be based on the record of the hearing, must discuss the issues, evidence, and statutory or regulatory provisions involved and must include specific findings of fact and the rationale of the decision. 42 C.F.R. 405.834; Carriers Manual § 12021, J.A. 37-39.[15] The decision of the carrier's hearing officer is final and binding upon the claimant (42 C.F.R. 405.835),[16] and the claimant has no right to a hearing by the Secretary or to judicial review.

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as the rights of the parties, the status of witnesses and of an attorney or other representative of the claimant, the role of a carrier witness, the hearing officer's opening statement, warnings that witnesses are subject to penalties for perjury and misrepresentation (see 42 U.S.C. (& Supp. III) 1395nn(a)), questioning of witnesses, and the closing of the hearing. Carriers Manual §§ 12019 and 12020, J.A. 28-37. To assist the hearing officers in conducting a hearing, a sample opening statement by the hearing officer is included as Exhibit 7 to Chapter XII of the Carriers Manual, at pages 12-58 to 12-59.

[15] To assist the hearing officers, a sample hearing officer's decision is included as Exhibit 8 to Chapter XII of the Carriers Manual, at pages 12-60 to 12-66.

[16] If the hearing officer's decision is favorable to the claimant, it must, of course, be effectuated by the carrier. Carriers Manual § 12022(B), J.A. 40; see also Deposition of Stanley Katz (at 167-168) in *Gadsden* v. *Mathews*, No. CV 75-2946-ALS (C.D. Cal., filed Dec. 20, 1976), included as Item 2 in the Appendix to Defendants' Reply to Plaintiffs' Memorandum of Points and Authorities in Support of Motion for Summary Judgment (hereinafter "Defendants' Appendix"). The Carriers Manual states that "[i]n rare instances" the carrier may believe the hearing officer exceeded his jurisdiction in issuing a decision. If so, although the carrier is not a party and cannot make a motion to reopen the case, the carrier is to request a reopening. The carrier is encouraged to contact the regional office of the Medicare Bureau if there is any uncertainty about whether the hearing officer exceeded his authority. Carriers Manual § 12022(B), J.A. 41.

Congress' preclusion of a right to a hearing conducted by the Secretary (which the district court nevertheless ordered) was the result of a deliberate and considered legislative decision,[17] in view of the requirement that the carriers themselves adopt fair review procedures and the relatively small amount of money involved in the typical Part B claim. For example, in contrasting the procedures available under Part B to the provision in 42 U.S.C. 1395ff for a hearing by the Secretary and judicial review of benefit determinations under Part A, the Senate report on the 1965 Act stated (S. Rep. No. 404, *supra*, at 55; emphasis added):

> Under the supplementary plan [Part B], carriers, *not the Secretary*, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under Part B where *claims will probably be for substantially smaller amounts than under Part A.*

See also H. R. Rep. No. 213, *supra*, at 47. Similarly, in 1972 Congress amended 42 U.S.C. 1395ff to limit the availability of review of Medicare benefit determinations, in part to "make clear that there is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B" (H. R. Conf. Rep. No. 92-1605, 92d Cong., 2d Sess. 61 1972)). This amendment, too, derived from Congress' concern about the burden associated with extending the review of small claims. See 118 Cong. Rec. 33992 (1972) (remarks of Sen. Bennett); *Mitchell* v. *Occidental Insurance, Medicare*, 619 F.2d 28, 30 (9th Cir. 1980); see also H.R. Rep. No. 92-231, 92d Cong., 1st Sess. 116 (1971); S. Rep. No. 92-1230, 92d Cong., 2d Sess. 213 (1972).

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[17] The government's brief in *United States* v. *Erika, Inc.*, No. 80-1594, 1980 Term (at 20-30) discusses the bar to *judicial* review of a carrier's decision on a Part B claim. That issue is not involved here because appellees conceded below, and the district court held (J.S. App. 5a), that the court was without jurisdiction to consider the merits of the carrier's decision denying individual claims.

4. The Secretary's Review Of Hearings Held by Carrier Hearing Officers

Although a Part B beneficiary does not have a *right* to have the Secretary review any individual reimbursement claim, the Secretary does monitor the carriers' performance in conducting Part B hearings in fulfillment of his responsibility to ensure that carriers comply with their statutory and contractual obligations.[18] The most systematic way in which this is accomplished is through a quarterly review of a sample of the hearings conducted by all carrier hearing officers.[19] The hearings reviewed are for the most part randomly selected according to the final digit of the beneficiary's social security number, but the Carriers Manual contains provisions to ensure the selection of at least one hearing by *every* hearing officer who rendered a decision during that quarter. Carriers Manual § 12023, J.A. 41-44. To facilitate the review, the carrier must forward to HHS the complete hearing file in the selected cases, including the transcript, all exhibits, and the decision. *Ibid.*

The purpose of this review, the Carriers Manual explains, is "[t]o help assure uniform application of due process principles in the hearing process and to assist in identifying areas in which the expansion or revision of the guidelines is necessary." § 12023, J.A. 41. If the review discloses any deficiencies in the procedures followed dur-

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[18] Of course, as an initial matter, the Act provides that the Secretary may not even enter into a contract with a carrier unless he first finds that the carrier "will perform its obligations under the contract efficiently and effectively." 42 U.S.C. 1395u(b)(2). Because the carrier has a contractual obligation, imposed by the Act itself, to establish and maintain procedures to afford beneficiaries the right to a "fair hearing" (see 42 C.F.R. 421.200(i)), the Secretary must be assured before entering into or renewing a contract that the carrier has the capacity to and will properly conduct such hearings. 42 C.F.R. 421.202(a).

[19] There were between 160 and 200 hearing officers in 1977. Katz Deposition, *supra* note 16, at 169. This figure includes both full-time and part-time hearing officers.

ing the hearings, these deficiencies are to be called to the carrier's attention, through the Medicare Bureau's regional office. On occasion, the hearing officer also may be requested to reopen a decision if the sample review reveals that a plainly erroneous decision was reached.[20]

In addition to this formalized review procedure, HHS occasionally will review hearing files in response to individual requests and complaints. Carriers Manual § 12023, J.A. 43.[21] The Medicare Bureau's on-site representative responsible for day-to-day monitoring of the carrier's operations also reviews the conduct of the appeals process, including hearings,[22] and an assessment of the appeals process often is included in HHS's Annual Contractor Evaluation Report assessing the carrier's overall performance for the year.[23]

II. THE PROVISION IN 42 U.S.C. 1395u(b)(3)(C) FOR A "FAIR HEARING" IS NOT UNCONSTITUTIONAL MERELY BECAUSE THE HEARING OFFICER WHO PRESIDES AT THE HEARING HAS BEEN APPOINTED BY THE CARRIER

Despite the detailed regulations and instructions, discussed in Point I, designed to ensure that beneficiaries under Part B of the Medicare Program and their assignees have a full opportunity to be heard at the evidentiary "fair hearing" required by 42 U.S.C. 1395u (b) (3) (C), the district court held that statutory provision unconstitutional under the Due Process Clause of the Fifth Amendment. The district court did not find that the *procedures* prescribed for the conduct of such hearings violate the Due Process Clause because they are

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[20] See generally Katz Deposition, *supra* note 16, at 6-8, 18, 63-65, 83-86, 117-119, 162-168, 171-173. Examples of memoranda sent to regional offices of the Medicare Bureau following a quarterly review are included in the Defendants' Appendix, *supra* note 16, at 363-396.

[21] See also Defendants' Appendix *supra* note 16, at 79.

[22] See Katz Deposition, *supra* note 16, at 164, 176, 217-218.

[23] See Katz Deposition, *supra* note 16, at 100. See, *e.g.*, the *Report for Occidental Life Insurance Co. for calendar year 1976*, at 19-20 (Defendants' Appendix, *supra* note 16, at 346-347).

insufficient to ensure that a claimant has a full opportunity to be heard.[24] Rather, the court struck down the federal statute solely because of the identity of the hearing officer who presided at the hearing. The district court concluded that a hearing officer appointed by the carrier cannot be regarded as an impartial decision-

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[24] The district court rejected appellees' only due process challenges to the hearing procedures, which related to the standard of proof employed and the weight that must be given to medical evidence. See J.S. App. 16a-17a. Appellees have not taken a cross-appeal from this aspect of the court's judgment.

In their equal protection challenge to Part B hearing procedures (as compared to Part A procedures), appellees did rely in part on the fact that carrier hearing officers do not have subpoena power while ALJs conducting Part A hearings do (see 42 U.S.C. 405(b), 405(d), 1395ff(b)(1) and 1395ii). Appellees do not appear to have argued, however, that a Part B hearing officer must have subpoena power as a matter of due process, in order to ensure the "fundamental fairness" of the hearing, even apart from an equal protection comparison to Part A hearings. Such an assertion would be both legally insubstantial and factually erroneous. See Friendly, *Some Kind of Hearing*, 123 U. Pa. L. Rev. 1267, 1282 & n.81, 1299 & n.165 (1975).

The Carriers Manual requires a hearing officer to assume an active role "to ensure that all evidence and witnesses will be available at the time and place set for the hearing" and "to obtain additional evidence which he regards as necessary to complete development of the case, through appropriate channels from the carrier, physician, hospital, or other source" (§ 12017(C), J.A. 28). There is no reason to expect that these sources of needed information would decline to furnish it, and Stanley Katz, the HHS official with overall responsibility for monitoring Part B hearings, stated in his deposition (*supra* note 16, at 190-191) that he was not aware of any situation where this actually had occurred. But if the carrier hearing officer nevertheless was unable to obtain evidence in a case, the *Secretary* could issue the necessary subpoena, pursuant to his authority under 42 U.S.C. 405(d) and 42 U.S.C. 1395ii. Section 405(d) grants the Secretary the power to issue subpoenas "[f]or the purpose of *any* hearing, investigation, or other proceeding authorized or directed" under Title II of the Social Security Act (emphasis added), and Section 405(d) applies to the Medicare Act "to the same extent as [it is] applicable" to Title II. 42 U.S.C. 1395ii. Thus, the Secretary's subpoena power is available as well for the purpose of "any hearing, investigation, or other proceeding" under the Medicare Act, which includes Part B carrier hearings. See Katz Deposition, *supra* note 16, at 191.

maker, and that an ALJ in HHS might be better qualified and therefore might conduct a more reliable hearing. Both grounds for the district court's holding are without merit.

A. A Hearing Officer Designated by the Insurance Carrier Satisfies the Due Process Requirement of an Impartial Decision-Maker

HHS's regulations and the Carriers Manual require a hearing officer to disqualify himself in any case in which he is or might be considered to be prejudiced or partial with respect to any party or in which he has a personal interest in the outcome. 42 C.F.R. 405.824; Carriers Manual § 12016(C), J.A. 23; compare *United States* v. *Will*, 449 U.S. 200, 212, 216-217 (1980). In concluding that a carrier-appointed hearing officer does not satisfy the due process requirement of an impartial decision-maker, the district court did not find that any individual hearing officer was prejudiced or partial in a particular case and had nevertheless presided at the hearing in violation of these requirements. To the contrary, the district court reached its conclusion "[w]ith all due respect for the personal integrity of Part B hearing officers" (J.S. App. 9a).

The district court's holding was much broader: that a Part B hearing officer, solely by virtue of his designation by the carrier, cannot be regarded as an impartial decision-maker, without regard to the circumstances of the particular case. This conclusion both disregards the determination by Congress and the Secretary that hearing officers appointed by the carriers could be and are independent and impartial decision-makers and seriously misapprehends governing due process principles.

1. *Congress and The Secretary Have Determined That a Hearing Officer Designated by the Carrier Would Be an Impartial Decision-Maker*

The district court's holding is directly contrary to Congress' legislative determination that hearing officers designated by the carriers—the Secretary's agents in

administering the Part B program—may be depended upon to be impartial decision-makers. Congress' judgment in this regard is expressed in the text of the very statutory provision the district court held unconstitutional, 42 U.S.C. 1395u(b)(3)(C), which directs the Secretary to ensure that his contracts with the carriers require them to "establish and maintain procedures" under which beneficiaries are afforded the right to a "*fair* hearing" (emphasis added). See also S. Rep. No. 404, *supra*, at 54 (carriers "would have to establish procedures for *fair* review of beneficiary complaints") (emphasis added). Congress reached the same conclusion in 1972, when it amended 42 U.S.C. 1395u (b)(3)(C) to add the $100 amount-in-controversy requirement for obtaining a carrier hearing. The committee reports noted that under the law as it then read, "people enrolled in the supplemental medical insurance program are *assured an opportunity for a fair hearing* by the carrier * * * regardless of the dollar amount at issue." H.R. Rep. No. 92-231, *supra*, at 116 (emphasis added); S. Rep. No. 92-1230, *supra*, at 213 (emphasis added).

Congress' judgment is reinforced by the careful manner in which the Secretary has implemented the statutory "fair hearing" requirement through the detailed procedural instructions described above. The Secretary has emphasized in the Carriers Manual that the Hearing Officer "must make independent and impartial decisions * * * and be objective and free of any influence which might affect impartial judgment as to the facts" (§ 12016(B), J.A. 22). Similarly, the official of HHS's Health Care Financing Administration responsible for monitoring Part B hearings stated:

> While a Hearing Officer appointed by a carrier acts as the agent of the Secretary in adjudicating a Part B claim, he must exercise an independent and impartial judgment as would an Administrative Law Judge * * * who renders a decision under Part A of Title XVIII or Title II of the Social Security Act. In the exercise of such judgment the Hearing Officer

> performs his adjudicative function independently of the carrier which appointed him * * *.

Affidavit of Stanley Katz, *supra* note 3, at ¶ 4; J.A. 12-13. This same HHS official also testified that the quarterly review of Part B hearings, as well as his own experience and pertinent statistics, had not revealed any evidence that the hearing officers had an institutional bias in favor of the carrier's previous position on a claim. Katz Deposition, *supra* note 16, at 178.

"[T]his Court has been willing to assume a congressional solicitude for fair procedure" (*Califano* v. *Yamasaki*, 442 U.S. 682, 693 (1979)). Accordingly, Congress' legislative determination that private insurance carriers properly may be entrusted to conduct fair hearings on behalf of the Secretary is entitled to great weight. Similarly, "substantial weight must be given to the good-faith judgments of the individuals charged by Congress with the administration of social welfare programs that the procedures they have provided assure fair consideration of the entitlement claims of individuals" (*Mathews* v. *Eldridge*, 424 U.S. 319, 349 (1976)). Nevertheless, the district court held that the impartiality of a hearing officer appointed by the carrier is compromised by what the court perceived to be the hearing officer's own "pecuniary interest" and by the prior involvement of the carrier in reviewing the reimbursement claim.

2. *The Impartiality of Part B Hearing Officers Is Not Compromised by Any Pecuniary Interest in the Decision*

The district court plainly erred in concluding (J.S. App. 10a) that a hearing officer, solely because of his designation by the carrier, has a "pecuniary interest" in the outcome of a claim. The carrier and the hearing officers it designates act as the agents of the Secretary in the adjudication of claims, and they have no more of a "pecuniary interest" in those adjudications than does the Secretary himself or do ALJs or other employees of HHS who make decisions on disputed benefit claims

arising under other parts of the Social Security Act. Cf. *Marshall* v. *Jerrico, Inc.*, 446 U.S. 238, 250 (1980).

The carrier with which the Secretary has contracted to administer the Part B program in a particular area does so on a not-for-profit basis.[25] Any claim found by the hearing officer to be meritorious is paid out of monies advanced to the carrier from the Federal Supplementary Medical Insurance Trust Fund (42 U.S.C. 1395u(a)(1)(B) and 1395u(c)), not out of the carrier's own funds. The hearing officer's fee likewise is paid out of the Trust Fund, as part of the reimbursement for the carrier's necessary and proper costs of administering the Part B program. *Ibid.* Thus, neither the hearing officer's own income nor that of the entity with which he is affiliated—the carrier—is affected in any way by whether the hearing officer rules in favor of or against the claimant. This case therefore bears no resemblance to *Connally* v. *Georgia*, 429 U.S. 245 (1977); *Tumey* v. *Ohio*, 273 U.S. 510 (1927); and *Ward* v. *Village of Monroeville*, 409 U.S. 57 (1972). See also *Marshall* v. *Jerrico, Inc.*, *supra*, 446 U.S. at 250-251.

The district court acknowledged (J.S. App. 10a) that the hearing officer's salary or fee in connection with a given case is unaffected by the decision he reaches in that case. The court nevertheless concluded (*ibid.*) that the hearing officer has a pecuniary interest in currying the carrier's favor because his *future* income might be affected by the carrier's decision whether, and how often, to call upon his services.[26] This concern is wholly speculative: the court cited no evidence that a carrier had ever engaged in conduct so improper as terminating or

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[25] See Katz Deposition, *supra* note 16, at 155; Defendants' Appendix, *supra* note 16, at 86.

[26] All the hearing officers of Occidental Life Insurance Company of California and Blue Shield of California, the only two carriers for which there is evidence in the record, were independent contractors, not employees of the carrier. See Defendants' Appendix, *supra* note 16, at 626-627, 681-685. However, employees of the carrier also may be designated as hearing officers.

substantially altering its relationship with a hearing officer because of rulings in favor of claimants,[27] and the HHS official responsible for monitoring the Part B hearing process testified that he did not know of any instance in which a hearing officer had been arbitrarily dismissed. Katz Deposition, *supra* note 16, at 181.

Moreover, quite aside from the absence of any factual support for the district court's speculation, there simply is no basis for it in logic. Because any claim found by the hearing officer to be meritorious is paid by the federal government, not the carrier, there is no reason to believe that the hearing officer could appeal to the carrier's financial interest (and receive greater consideration in the future as a reward) by rendering a decision against the claimant. To the contrary, the carrier's contract with the Secretary obligates it to determine correctly the amount of payments required to be made under the Act for covered services and to make those payments. 42 U.S.C. (& Supp. III) 1395u(a)(1)(A) and (B), 1395u(b)(3); 42 C.F.R. 421.200; see also 42 C.F.R. 405.803(a) and (b).

The Secretary may terminate the contract at any time if he finds, after notice and opportunity for a hearing, that the carrier has failed substantially to carry out the contract or is doing so in a manner inconsistent with the efficient and effective administration of the Part B program. 42 U.S.C. 1395u(b)(4); 42 C.F.R. 421.205(a). Thus, in order to ensure compliance with the contract and thereby avoid possible termination, it would be in the carrier's interest—and therefore presumably also in the interest of a hearing officer seeking to maintain the favor of the carrier—to insist that the hearings are scrupulously fair and that claims are paid when the Act

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[27] The record makes clear that HHS would regard it as highly improper for a carrier to dismiss a hearing officer because of dissatisfaction with a particular decision, in the same manner as it would be improper to dismiss him because of his race, religion, or ethnic origin. Katz Deposition, *supra* note 16, at 113. A hearing officer could bring such an incident to the attention of HHS. *Id.* at 114.

and implementing regulations so require and are disallowed when they do not. There is no reason to believe that the carrier would jeopardize its contractual relationship with the Secretary by exerting influence on a hearing officer to deny an otherwise meritorious claim or that the hearing officer would believe that he could ingratiate himself with the carrier by doing so. And the knowledge that HHS conducts a random sample of the hearings conducted by all hearing officers each quarter, and on occasion will review an individual file following a complaint, would operate as a significant deterrent to such conduct in any event.

Nor is there any reason to believe that the carrier would seek to curry favor with HHS by pressuring its hearing officers to deny otherwise meritorious claims in order to hold down the overall cost of the Part B program. See Motion to Affirm 25 n.10. The conduct of hearings is but one aspect of a carrier's overall responsibility in administering the Part B program. The total amount in controversy in *all* Part B hearing requests annually is less than two-tenths of 1% of the more than $10 billion in Part B benefits that now are paid out by carriers each year.[28] Against this backdrop, any possibility that a decision of a hearing officer on an individual claim involving perhaps several hundred dollars might be viewed as inconsistent with a desire to hold down costs, that carriers therefore might violate their statutory and contractual obligations by pressuring hearing officers to skew the outcome of their

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[28] There were 26,171 requests for Part B hearings in calendar year 1980, and the average amount in controversy in Part B hearings during the first quarter of 1980—the most recent quarter for which figures are available—was $610. See Health Care Financing Administration, Bureau of Program Operations, *Part B Carrier Appeals Report*, Tables B and F (Jan.-Mar. 1981). If the latter figure remained constant throughout 1980, the total amount in controversy in all Part B hearing requests would have been approximately $16 million. This would be only .16% of the total of $10.44 billion paid out in benefits by carriers during fiscal year 1980. See *1981 Annual Report of the Federal Supplementary Medical Insurance Trust Fund*, H.R. Doc. No. 97-68, 97th Cong., 1st Sess. 21 (1981).

hearings in order to avoid such a result, and that the hearing officers might respond to such pressure, is "so remote, trifling and insignificant that it may fairly be supposed to be incapable of affecting the judgment of or of influencing the conduct of an individual." *Tumey* v. *Ohio*, *supra*, 273 U.S. at 531. See also *Marshall* v. *Jerrico, Inc.*, *supra*, 446 U.S. at 251-252.

3. *The Impartiality Of Carrier Hearing Officers Is Not Tainted by Prior Involvement In the Cases They Consider*

The district court also concluded that the impartiality of a hearing officer appointed by the carrier is tainted by "prior involvement." As the court acknowledged (J.S. App. 9a), a carrier hearing officer may not participate personally at any prior stage of the carrier's review of the claim. See 42 C.F.R. 405.824; Carriers Manual § 12016(B), J.A. 22. Thus, there is no risk that a hearing officer personally might have prejudged the merits of a particular claim. Compare *Gibson* v. *Berryhill*, 411 U.S. 564, 578-579 (1973). The court reasoned (J.S. App. 9a), however, that a hearing officer has been "vicariously involved" in reviewing any claim he considers because *other* personnel affiliated with the carrier previously had considered and denied the claim. In the court's view (*ibid.*), a hearing officer's impartiality is compromised because he might be reluctant to rule in the claimant's favor by directly overruling the carrier's decision. The court's reasoning is seriously flawed.

a. If Congress had not provided for the Secretary to contract with carriers for the determination and payment of Part B benefits, but had instead chosen to have these tasks performed by the Secretary, appellees could not seriously contend that the Due Process Clause would prohibit one HHS employee from holding a hearing on a disputed claim simply because another employee of HHS previously had reviewed and denied the same claim. Congress typically assigns the entire administrative consideration of a matter to "the Secretary," with the understanding that the various stages of that consideration will be reassigned to different employees of the same department, under the overall supervision of the Secretary.

See, *e.g.*, 42 U.S.C. 405(b). To suggest that such a division of responsibilities among employees within a government agency violates the Due Process Clause, because of a supposed institutional bias, would "assume[] too much and would bring down too many procedures designed, and working well, for a governmental structure of great and growing complexity." *Withrow* v. *Larkin*, 421 U.S. 35, 49-50 (1975), quoting *Richardson* v. *Perales*, *supra*, 402 U.S. at 410. See, *e.g.*, *Morrissey* v. *Brewer*, 408 U.S. 471, 485-486 (1972); *Goldberg* v. *Kelly*, 397 U.S. 254, 271 (1970).

For the reasons previously explained, however, Congress chose to provide for the Secretary to contract with private insurance carriers for the administration of payments under Part B rather than to authorize him to appoint additional employees in HHS for this purpose. But Congress made clear that these carriers and the employees they appoint, like the HHS employees who administer other titles of the Social Security Act, perform their undertaking "on behalf of the Secretary, carrying on for him the governmental administrative responsibilities imposed by the [Act]." S. Rep. No. 404, *supra*, at 54; see also note 9, *supra*. The Carriers Manual stresses that this principle applies equally to a hearing officer appointed by the carrier, stating that "although he is not an officer of the Federal Government he is nevertheless acting on its behalf and must comply with the provisions of the Medicare law, regulations, and instructions" (§ 12016(C), J.A. 24). Because all persons involved in the administration of benefits under the various titles of the Social Security Act serve as agents of the Secretary, whether appointed directly by him or by the Part B carrier, the due process rule that permits one employee of an agency to review the decisions of another employee applies equally to permit a hearing officer designated by a Part B carrier to conduct a hearing on a claim that an employee of the carrier previously had reviewed.[29]

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[29] Often the government may obtain the services of individuals to carry out governmental tasks either by appointment to a position or by contract. Cf. *United States* v. *Hopkins*, 427 U.S. 123 (1976).

Moreover, as this Court has emphasized, there is "a presumption of honesty and integrity in those serving as adjudicators." *Withrow* v. *Larkin*, *supra*, 421 U.S. at 47. The burden of overcoming this presumption is a "difficult" one, requiring a convincing showing that, "under a realistic appraisal of psychological tendencies and human weaknesses," the particular adjudicatory procedure "poses such a risk of actual bias or prejudgment that the practice must be forbidden if the guarantee of due process is to be adequately implemented." *Ibid.*

In *Withrow* v. *Larkin*, the Court applied this principle in rejecting an accusation that members of a body responsible for adjudicating a matter were biased because of *their own* prior involvement in the matter in the course of investigation and issuance of a complaint. See also *FTC* v. *Cement Institute*, 333 U.S. 683, 700-703 (1948); *NLRB* v. *Donnelly Garment Co.*, 330 U.S. 219, 236-237 (1947). Similarly, in *Richardson* v. *Perales*, *supra*, the Court rejected the contention that a hearing examiner in the Social Security Administration could not be regarded as impartial because (like a hearing officer appointed by a carrier under Part B of the Medicare Act) he gathers evidence in the case and might therefore lean toward a decision in favor of the evidence he has gathered. 402 U.S. at 408-410.

If Congress had authorized the Secretary to contract directly with certain individuals to review Medicare Part B benefit claims and with other individuals to serve as hearing officers on those claims, these individual *contractors* would be situated no differently, for purposes of the due process issue in this case, than employees *appointed* by the Secretary in HHS. Accordingly, it could not seriously be contended that the Due Process Clause would bar a hearing officer retained by contract with the Secretary from considering a claim that previously had been denied by another person whose services had been obtained under a separate contract with the Secretary. The only difference here is that the Secretary has not entered into separate employment contracts with each person who passes on Part B claims in a particular geographical area; he has entered into a single contract with the carrier, which in turn appoints employees to process claims and appoints or contracts with hearing officers to hold hearings on the claims. This difference in the contractual relationship does not alter the due process analysis.

The presumption of honesty and integrity must be even stronger—and the resulting burden on the person alleging bias even heavier—where, as here, the adjudicator has had no personal involvement whatever in the particular matter prior to the hearing and the alleged bias is said to result from the prior involvement of *others* in the case. Yet the district court offered nothing to suggest that appellees had sustained their burden of showing that a carrier hearing officer charged with impartially and objectively reviewing evidence received at a de novo hearing and issuing a reasoned decision on the basis of that evidence will ignore his responsibility merely because another employee of the carrier previously had reviewed the claim and denied it. Nor is there any evidence in the record to substantiate the suggestion of bias. As the district court acknowledged (J.S. App. 13a), the record shows that in the cases considered by hearing officers from 1975 to 1978, the carrier's previous decision on the claim was reversed, in whole or in part, in between 42% and 51% of the cases. *Ibid.*[30] These data obviously do not reflect a reluctance to overturn prior determinations; to the contrary, they "attest[] to the fairness of the [carrier review] system and refute[] the implication of impropriety." *Richardson* v. *Perales*, *supra*, 402 U.S. at 410.[31]

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[30] The experience is the same prior to the hearing stage: the carriers' review determinations resulted in a reversal of the initial determination in between 51% and 57% of the cases between 1975 and 1978. J.S. App. 13a.

[31] Appellees seek to avoid the significance of these statistics by relying (Motion to Affirm 23 n.10) upon this Court's observation in *Mathews* v. *Eldridge*, *supra*, that "[b]are statistics rarely provide a satisfactory measure of the fairness of a decision-making process" (424 U.S. at 346). This reliance is misplaced. The evidence of the reversal rate relied upon by the plaintiff in *Mathews* v. *Eldridge* was intended to show that decisions made *prior* to the post-deprivation hearing were inaccurate and therefore that the pretermination process was inadequate without ~~the need for~~ a hearing at that stage. 424 U.S. at 346-347. In contrast, here, as in *Richardson* v. *Perales*, the statistics were offered by the Secretary to show that the *hearing process itself* is impartial. Whatever relevance reversal rates gen-

b. In concluding that carrier-appointed hearing officers cannot be regarded as impartial decision-makers, the district court relied in part on Canon 3-C(1)(b) of the Code of Judicial Conduct, which provides that a judge should disqualify himself in any case where "a lawyer with whom he previously practiced law served during such association as a lawyer concerning the matter." Congress adopted this standard by statute for federal judges in 28 U.S.C. 455(b)(2), which requires a judge to disqualify himself "[w]here in private practice * * * a lawyer with whom he previously practiced law served during such association as a lawyer concerning the matter." This rule of judicial ethics has no application here, even by analogy.

Section 455(b)(2) applies where the judge's former partner or associate served as a "lawyer"—*i.e.*, an *advocate*—in the matter. Because attorneys who practice together have a shared professional and financial stake in the outcome of a case, a judge's impartiality might reasonably be questioned if he previously was associated with a lawyer who was an advocate in the matter during their period of association.[32] But a carrier under Part B of the

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erally might have in demonstrating the accuracy of decisions at the previous stage of review, the reversal rate of between 42% and 51% established in this case plainly demonstrates that hearing officers are not reluctant to overturn these decisions when the law and facts so indicate.

This Court's decision in *Mathews* v. *Eldridge* did not overrule the holding in *Richardson* v. *Perales* that a high reversal rate is significant for this purpose and "attests to the fairness of the system and refutes the implication of impropriety." Moreover, in *Mathews* v. *Eldridge*, the Court viewed the statistics presented as *relevant*, even if not controlling. 424 U.S. at 347. Because the only relevant statistical evidence in the record in this case cuts strongly *against* any suggestion of institutional bias in the hearing procedure Congress has established, the district court's finding of partiality was especially ill-considered.

[32] Even this rule of disqualification does not apply where the judge and the lawyer practiced together in the government, unless the judge personally participated in or rendered advice on the matter. See 28 U.S.C. 455(b)(3). Although this exception no doubt derives in part from necessity, in that many federal judges pre-

Medicare program, like the Secretary with respect to determinations under other titles of the Social Security Act that he administers directly, "operates essentially, and is intended so to do, as an *adjudicator* and not as an advocate or adversary" ((*Richardson* v. *Perales*, *supra*, 402 U.S. at 403; emphasis added)); see also page 20, *supra*). Accordingly, the hearing officer appointed by the carrier, like the hearing examiner (now the ALJ) in *Perales*, acts as "an examiner charged with developing the facts" and does "not act as counsel." *Id.* at 410. And unlike lawyers in private practice together, the hearing officer and the other persons affiliated with the carrier have no shared pecuniary or professional interest in either favoring or opposing a Part B Medicare claim on the merits. They are interested only "in an accurate and just decision" (*Lassiter* v. *Department of Social Services*, *supra*, slip op. 8). For this reason, appellees err in relying on the rule of judicial ethics, embodied in 28 U.S.C. 455(b)(2), requiring a judge's disqualification if he previously was associated in private practice with an *advocate* in the matter.

In addition to the specific prohibition in 28 U.S.C. 455(b)(2), just discussed, appellees also rely (Motion to Affirm 17) on the general requirement in 28 U.S.C. 455

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viously served in the Executive Branch (see S. Rep. No. 93-419, 93d Cong., 1st Sess. 5-6 (1973); H.R. Rep. No. 93-1453, 93d Cong., 1st Sess. 5-6 (1973)), it also no doubt reflects the view that lawyers in the government, unlike those in private practice, do not have a shared financial interest in the matter and have a duty to see that justice is done rather than simply to see their client prevail. ABA Comm. on Professional Ethics, *Formal Opinion, No. 342* (Nov. 24, 1975), 62 A.B.A.J. 517, 519 (1976); see *United States* v. *Caggiano*, 660 F.2d 184, 190-191 (6th Cir. 1981). Because the carrier's employees and hearing officers serve as agents of the Secretary, herewith they have the same responsibility to see that justice is done as do employees of HHS who pass on claims, and because they have no financial interest in the outcome, the limited rule of disqualification in 28 U.S.C. 455(b)(3) for judges who previously practiced in the government would be relevant if appellees' analogy to the rules of judicial disqualification otherwise were apt. But that analogy is misplaced, for the reasons given in the text.

(a) that a federal judge disqualify himself in any proceeding in which "his impartiality might reasonably be questioned." They assert (without citation to any authority) that, heeding this admonition, judges "routinely" disqualify themselves in matters involving their former law firms even if the matter was not actually pending in the law firm before the judge left. In appellees' view (Motion to Affirm 18 n.9), this practice indicates that the basis for a judge's disqualification goes beyond situations where the judge shared his partner's pecuniary or professional interest, as an advocate, in the outcome of the particular case. Appellees apparently also appear to argue by analogy that *even former* employees of the carrier may not be retained by the carrier to conduct hearings on Part B claims that arose after they ceased to work for the carrier as full time employees.

This line of reasoning is equally flawed. First, the practice appellees cite has not been uniformly accepted as a rule of judicial ethics,[33] much less of due process. And such a rule was *not* adopted by Congress as a basis for a mandatory disqualification even for federal judges, as is made clear by the fact that the provision that *expressly* addresses the situation involving the judge's former law firm, 28 U.S.C. 455(b)(2), requires disqualification *only* where the judge's former partner or associate actually handled the matter while the two were in practice together. In any event, the practice appellees cite pertains to situations in which the judge and a lawyer for a party to the proceeding previously practiced together as *advocates*, not adjudicators, as here.

Finally, the requirement in 28 U.S.C. 455(a) that a judge disqualify himself in any proceeding "in which his impartiality might reasonably be questioned" states a standard to be applied by individual judges in particular

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[33] See *Jewell Ridge Corp.* v. *Local No. 6167, United Mineworkers of America*, 325 U.S. 161 (1945); *id.* at 897 (Jackson, J., concurring in the denial of the petition for rehearing); Frank, *Disqualification of Judges*, 56 Yale L. J. 605 (1947); cf. *Laird* v. *Tatum*, 409 U.S. 824, 829 (1972) (Rehnquist, J. mem.).

cases, such that "if there is a reasonable factual basis for doubting the judge's impartiality, he should disqualify himself *and let another judge preside over the case*" (S. Rep. No. 93-419, *supra*, at 5; emphasis added). It is not to be construed, even as a statutory matter, as requiring disqualification of *all* federal judges in an entire category of cases in which Congress clearly intended them to sit. Cf. *United States* v. *Will*, *supra*, 449 U.S. at 216-217. Similarly, it cannot be thought, by analogy, to require the "disqualification" of all carrier hearing officers under Part B of the Medicare Act, because Congress manifestly intended these hearing officers, not the Secretary, to conduct Part B hearings.[34]

B. Part B Claimants Do Not Have an Independent Due Process Right to a Hearing by the Secretary

The district court also concluded that, even aside from the question of possible bias, a claimant under Part B of the Medicare program has a due process right to a hearing by the Secretary, in addition to a hearing conducted by a carrier-appointed hearing officer,[35] because a hearing conducted by the Secretary might be more reliable. This conclusion, too, is entirely without merit.

In considering this issue, it is important to emphasize once again that the due process question presented is not

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[34] Appellees' reliance (Motion to Affirm 15) on *Commonwealth Coatings Corp.* v. *Continental Casualty Co.*, 393 U.S. 145 (1968), is misplaced. There, the arbitrator had failed to disclose his prior business relationship with one of the parties to the arbitration. Here, in contrast, the fact that hearing officers appointed by the carriers will conduct hearings under the Part B program is disclosed on the face of the Medicare Act itself.

[35] The district court indicated in its opinion (J.S. App. 16a) that the existing system of separate carrier-conducted hearings could be terminated and *replaced* with ALJ hearings in HHS, rather than requiring a *second* de novo evidentiary hearing in HHS. But because 42 U.S.C. 1395u(b)(3)(C) requires the carrier to conduct such hearings, the Secretary would not appear to be free to abandon this step in the proceedings (at least not without a waiver from the beneficiary), and the district court's judgment does not provide for omission of the carrier hearing. J.S. App. 36a.

whether an evidentiary hearing is required or whether a hearing by the carrier affords the claimant a full opportunity to be heard; an evidentiary hearing concededly *is* required by 42 U.S.C. 1395u(b)(3)(C), and the procedures adopted by the Secretary, plainly afford the claimant a full opportunity to be heard at that hearing. Thus, the far narrower question presented is whether a Part B hearing that otherwise comports fully with the requirements of the Due Process Clause is constitutionally defective solely by virtue of the identity of the person who presides at the hearing. The district court concluded that it is and held 42 U.S.C. 1395u(b)(3)(C) unconstitutional on this ground as well.

1. ***Appellees Have Not Shown, and the District Court Did Not Find, That the Hearing Officers Appointed by the Carriers Are Not Qualified to Conduct Part B Hearings***

As this Court has stated, "[t]he guarantees of due process call for a 'hearing appropriate to the nature of the case.'" *United States* v. *Raddatz*, 447 U.S. 667, 677 (1980), quoting *Mullane* v. *Central Hanover Bank & Trust Co.*, 339 U.S. 306, 313 (1950). Because Congress concluded that private insurance carriers, rather than a government agency, could most efficiently pay claims and otherwise administer the Part B insurance program on a day-to-day basis, it was reasonable for Congress to conclude that an evidentiary hearing conducted by the carrier, not by the Secretary, is the "hearing appropriate to the nature of the case" under Part B.

The district court nevertheless held that the Due Process Clause requires Part B hearings to be conducted by the Secretary because, as compared with ALJs in HHS, the hearing officers appointed by the carriers receive what the court believed to be insufficient formal training by HHS, and because they do not have to satisfy "specific" eligibility criteria, such as having a law degree. Accordingly, without explanation or citation to supporting evidence, the court simply "assumed that additional safeguards"—*i.e.*, hearings conducted by ALJs in HHS, who

must have a law degree and who the court evidently believed receive more appropriate training—"would reduce the risk of erroneous deprivation of Part B benefits" (J.S. App. 14a).

But the district court's comparison of the *relative* qualifications and training of carrier hearing officers and ALJs is beside the point. The court was not empowered to order what it viewed as improvements in existing statutory procedures if those procedures meet constitutional requirements. The relevant inquiry is whether the hearing officers appointed by the carriers, as Congress provided, satisfy whatever *absolute* standard of minimum competence the Due Process Clause requires of the decision-maker in order for the opportunity to be heard at an administrative hearing to be "meaningful" (*Parratt* v. *Taylor*, *supra*, slip op. 12).

As pointed out above, the Carriers Manual provides that the carrier should designate as a hearing officer "an attorney or other qualified individual with the ability to conduct formal hearings and with a general understanding of medical matters and terminology." § 12016 (B), J.A. 22. The Carriers Manual further provides that the hearing officer "must have a thorough knowledge of the Medicare program and the statutory authority and regulations upon which it is based, as well as rulings, policy statements, and general instructions pertinent to the Medicare Bureau." *Ibid.* A hearing officer who satisfies these requirements plainly is capable of affording a Part B beneficiary or his assignee a "meaningful" opportunity to be heard at the fair hearing required by 42 U.S.C. 1395u(b)(3)(C).

Moreover, the district court did not find that any individual hearing officer appointed by a carrier does not, in fact, possess the minimum qualifications required by the Due Process Clause, notwithstanding the standards set forth in the Carriers Manual. In any event, there is no basis on the present record for such a conclusion. The record contains information on the hearing officers of only two Part B carriers: Occidental Life Insurance Company, the carrier in Southern California, and Blue

Shield of California, the carrier in Northern California. All three of Occidental's hearing officers were attorneys; one of the three was a retired ALJ, another had been a practicing attorney for 20 years, and the third had 42 years of experience in the insurance industry and was then self-employed as an insurance adjuster.[36] Of the six hearing officers of Blue Shield, one was a retired ALJ in the Social Security Administration and the other five had extensive careers in medicine or medical insurance.[37]

Appellees, like the district court (see J.S. App. 14a), appear to take issue principally with the fact that HHS does not require carrier hearing officers to be attorneys. See Motion to Affirm 26-27.[38] This Court has made clear, however, that the Due Process Clause does not require that the person who presides at an administrative hearing be a lawyer. See, *e.g.*, *Parham* v. *J.R.*, 442 U.S. 584, 607 (1979); *Morrissey* v. *Brewer*, 408 U.S. 471, 486, 489 (1972). A Part B carrier reasonably could conclude, therefore, that a person with a medical background or experience in reviewing medical claims is suitably qualified to conduct a hearing that often entails the review of medical evidence or insurance-related data regarding the reasonable and customary charges for medical services, even if the person does not have a law degree. See *Parham* v. *J.R.*, *supra*, 442 U.S. at 607.

The district court also relied in part (J.S. App. 13a-14a) on what it believed to be insufficient formal train-

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[36] See Defendants' Appendix, *supra* note 16, at 626-627, 661.

[37] These five consisted of the former Manager of Medicare Liaison for Blue Shield, a physician who was a medical advisor to Blue Shield, the former Chief of Medical Services of an Army installation who later was employed with Blue Shield for 11 years, the former Administrator of Medicare Liaison for Blue Shield, and a person with 28 years of experience as an officer of and consultant to the Blue Cross Association and National Association of Blue Shield Plans. No information was available on a seventh hearing officer who ceased doing this work in 1977. See Defendants' Appendix, *supra* note 16, at 681-685.

[38] As of 1977, however, approximately 50% of the hearing officers *were* attorneys. Katz Deposition, *supra* note 16, at 110.

ing by HHS of carrier hearing officers. But this issue would be relevant only if it were shown that carrier hearing officers are not competent to conduct Part B hearings without such training. As explained above, no such showing was made in this case. Moreover, HHS *does* furnish the hearing officers with detailed instructions in Chapter XII of the Carriers Manual regarding the conduct of Part B hearings, including a sample opening statement and decision, and HHS *does* conduct periodic training seminars for Part B hearing officers.[39] In addition, new hearing officers typically observe hearings conducted by experienced hearing officers before assuming their responsibilities,[40] and, as explained above, HHS conducts a quarterly review of carrier hearings to ensure that established procedures are being followed.[41] Neither the district court nor appellees have shown that these training and monitoring measures are insufficient or inadequate.

Even assuming, arguendo, that the district court could have concluded on the present record that carrier-appointed hearing officers do not possess the minimum degree of competence required by the Due Process Clause, the appropriate remedy in that event would have been for the court to order HHS to take measures to improve the qualifications of the hearing officers that the *carriers* appoint, not to declare unconstitutional the Act of Congress providing for their appointment by carriers and to order that Part B hearings be conducted by the Secretary—the very approach Congress rejected. For this reason, and because on the record in this case carrier-appointed hearing officers do satisfy the minimum requirements of due process, there was no occasion for the district court to engage in a "balancing" process under

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[39] Katz Deposition, *supra* note 16, at 121-122, 184-185; Defendants' Appendix, *supra* note 16, at 577-578.

[40] Defendants' Appendix, *supra* note 16, at 628, 687.

[41] The Medicare Bureau also will offer assistance to a hearing officer when requested. Katz Deposition, *supra* note 16, at 129-130.

the three-part test announced in *Mathews* v. *Eldridge* in order to determine whether some *other* approach—*i.e.*, hearings by ALJs in HHS—would be appropriate.

2. *Under the Three-Part Test in* Mathews v. Eldridge, *the Due Process Clause Does Not Require That Part B Hearings Be Conducted by the Secretary*

The Due Process Clause does not require that hearings under Part B be conducted by the Secretary even if, contrary to the position we advance in the previous section, the relative qualifications of carrier hearing officers and ALJs should be reviewed under the three-part test announced by this Court in *Mathews* v. *Eldridge*, *supra*. In *Mathews* v. *Eldridge*, the Court held (424 U.S. at 335) that identification of the dictates of due process in any given situation requires consideration of three distinct factors:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.

See also *Little* v. *Streater*, No. 79-6779 (June 1, 1981), slip op. 4; *Lassiter* v. *Department of Social Services*, No. 79-6423 (June 1, 1981), slip op. 8; *United States* v. *Raddatz*, *supra*, 447 U.S. at 677. The district court seriously misapplied this test here.

a. The private interest at stake in this case is the claimant's interest in receiving the requested level of reimbursement for the medical services that gave rise to the particular claim. The carrier's decision on this discrete issue does not affect the beneficiary's ability to continue to participate in the Medicare program generally or jeopardize his right to receive benefits under it in

other circumstances. Compare *Mathews* v. *Eldridge*, *supra*; *Goldberg* v. *Kelly*, *supra*. Congress *has* afforded a right to an administrative hearing by the Secretary on the question of an individual's eligibility to participate in the Part B program. 42 U.S.C. 1395ff(b)(1)(B); see also *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773, 786-787 (1980). Congress concluded that the "hearing appropriate to the nature of the case" (*United States* v. *Raddatz*, *supra*, 447 U.S. at 667) on the issue of eligibility is one conducted by the Secretary, no doubt because eligibility is a matter uniquely within the competence of the Secretary, who must make related determinations under Title II of the Social Security Act (see 42 U.S.C. (& Supp. III) 402 and 1395*o*), and because a decision on this issue will have a substantial and lasting impact on the individual.

In contrast, the amount of money at issue in an individual Part B claim typically is relatively small. Statistics compiled by HHS show that during the first quarter of 1980, the most recent period for which figures are available, the average amount in controversy in a Part B hearing was $610. See note 28, *supra*. But as explained above (see note 13, *supra*), a claimant may aggregate for purposes of the hearing all claims for which review determinations were rendered during the previous six months, even if those claims are unrelated. For this reason, the average amount in controversy on each individual *claim* considered at a Part B hearing is substantially less than $610. Moreover, as the district court acknowledged (J.S. App. 13a), Medicare benefits are not paid on the basis of financial need, and a denial of a particular claim therefore cannot be presumed to cause a grievous deprivation to the beneficiary in the generality of cases. See *Mathews* v. *Eldridge*, *supra*, 424 U.S. at 340-341.[42]

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[42] Indeed, a substantial percentage of Part B claims are presented by the physician or other person who furnished the services, not by the beneficiary himself. Statistics compiled by HHS for the month of July 1981 show that more than 50% of all claims received had been assigned by the beneficiary. Health Care Financing Administra-

Finally, in evaluating the individual interest involved, we believe it is relevant that the payment of medical insurance claims such as those covered by Part B of the Medicare Act traditionally has been administered by private insurance carriers and that the administration of Part B claims was intended by Congress to parallel that experience. We also believe that it is relevant that Part B establishes a *voluntary* program of supplementary medical insurance and that the individual beneficiary is free to opt out of the program pursuant to 42 U.S.C. 1395q(b) and purchase a comparable private insurance plan. Cf. *Arnett* v. *Kennedy*, 416 U.S. 134, 152-154 (Rehnquist, J.) (1974); *McElrath* v. *United States*, 102 U.S. 426, 440 (1880).

b. In considering the risk of erroneous deprivation, the district court found the record "inconclusive" (J.S. App. 13a) on whether existing carrier review procedures pose a high risk of an incorrect reimbursement determination. Contrary to the district court's view, however, the statistics showing a partial or total reversal in more than 40% of the cases in which a carrier hearing is held (*ibid.*) establish that hearing officers give close scrutiny to the claims.

Moreover, the district court cited no evidence to support the contrary proposition: that carrier hearing officers do *not* give close scrutiny to such claims and that the current system poses a high risk of error solely because the hearings are conducted by carrier-appointed hearing officers rather than ALJs in HHS. The Court simply "assumed" that ALJ hearings would reduce the risk of error because hearing officers need not be lawyers and are trained principally by the carriers, not HHS.

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tion, Bureau of Program Operations, *Part B Carrier Workload Report, Table A* (July 1981). Most physicians and other assignees could not be expected to suffer a grievous loss if an individual assigned claim is denied. It is true that, in many situations, the physician or other assignee of a Part B hearing is free to seek to recover from the beneficiary if coverage is denied; but he may *not* recover from the beneficiary any amount in excess of what the carrier determines to be the reasonable charge for the services. 42 U.S.C. 1395u(b)(3)(B)(ii)(I); 42 C.F.R. 405.1675(a)(1)(i).

As explained above, the record in this case furnishes no support for the district court's assumption; and there is, in any event, no reason to expect that the assumption is valid. For example, the principal issue in the majority of Part B hearings is the "reasonable charge" for the particular services. See HCFA Report, *supra* note 28, Table F. Decisions on this issue "typically turn upon mathematical calculations" (*Gray Panthers* v. *Schweiker*, 652 F.2d 146, 171 (D.C. Cir 1981), quoting *Gray Panthers* v. *Califano*, 466 F. Supp. 1317, 1324 (D.D.C. 1979)) that non-lawyer hearing officers appointed by the carriers presumably can perform as well as an ALJ in HHS. Calculation of the "reasonable charge" requires consideration of the customary charge made by the particular physician or other furnisher of services and the prevailing charge in the locality—information peculiarly within the knowledge of the carrier responsible for administering the Part B program in the area. See *Kechijian* v. *Califano*, 621 F.2d 1, 3 (1st Cir. 1980); cf. *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283, 289 (8th Cir.), cert. denied, 429 U.S. 977 (1976). Indeed, carrier hearing officers who specialize in considering Part B claims have developed an expertise on the reasonable charge issue; ALJs in HHS, in contrast, even those who hear cases arising under Part A of the Act, do not have a comparable expertise.[43]

c.. The substantial cost and disruption to the Medicare program and other programs administered by HHS

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[43] The individual beneficiary under Part A does not have a right to a hearing with respect to the "reasonable cost" of services that are covered by Part A (see 42 C.F.R. 405.705(a), as amended, 45 Fed. Reg. 73932 (1980); *Alabama Hospital Association* v. *United States*, No. 465-79C (Ct. Cl. June 17, 1981), cert. pending, No. 81-875); that is a matter between the hospital and the fiscal intermediary, because the hospital is reimbursed directly by the intermediary (42 U.S.C. (& Supp. III) 1395g and 1395h) and cannot recover from the individual beneficiary any amount of the cost that is found not to be reasonable (42 U.S.C. 1395cc(a)(1)(A)). Reasonable cost disputes are considered by the Provider Reimbursement Review Board established by 42 U.S.C. 1395*oo*, not by ALJ's in HHS's Office of Hearings and Appeals.

of providing de novo ALJ hearings to duplicate the statutory "fair hearing" by the carrier cannot be denied. There are more than 27 million participants in the program, and more than 150 million reimbursement claims are filed each year. Even if only a fraction of these claims eventually were appealed to ALJs under the district court's order, the order nevertheless would add thousands of cases each year to the caseload of the already severly overburdened corps of ALJs in HHS.[44] Such a result would delay the final resolution of Part B claims and the other matters with which they would compete on the ALJs' docket, and would substantially undermine Congress' decision to entrust the administration of the Part B program to the carriers.

The district court reasoned (J.S. App. 14a) and appellees contend (Motion to Affirm 29, 32) that the administrative cost would not be substantial because ALJs in HHS already conduct hearings under Part A of the Medicare program and that a "new bureaucracy" therefore would not be needed to hear Part B claims. This argument misses the point. The administrative burden does not depend on whether a new organizational unit would have to be created in HHS. All ALJ hearings in HHS are now conducted by the Office of Hearings and Appeals in the Social Security Administration, and the Part B

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[44] The record shows that more than 20,000 Part B hearings were requested in fiscal years 1977 and 1978. J.A. 44. Indeed, more recent HHS figures reveal that 26,171 hearings were requested in calendar year 1980. HCFA *Report*, *supra* note 28, at Table B. In addition, we have been informed by HHS that claims were denied after a hearing, in whole or in part, in 16,511 of those cases. Although the residual amount in controversy in some of these 16,511 cases might not equal or exceed the $100 amount necessary to obtain an ALJ hearing under the district court's order, a significant percentage could be expected to be appealed to ALJs. For example, HHS data reveal that, prior to Justice Rehnquist's June 12 order granting a stay, notices of a right to an ALJ hearing were sent to approximately 8,000 of the claimants who had received adverse carrier hearing officer decisions between May 1, 1980 and April 30, 1981, and that 2,313 of these recipients requested ALJ hearings. The actual hearings in these cases have been postponed pending a decision in this case.

hearings ordered by the district court would be conducted by that office as well. The number of ALJ hearings under Part A of the Act is far less than the number of carrier hearings under Part B.[45] Therefore, even viewing Medicare hearings in isolation, Part B hearings overshadow those now conducted under Part A.

More to the point, however, is the fact that Part A hearings at present comprise only a very small percentage of ALJ hearings in HHS. Approximately 95% of those hearings are in disability cases.[46] HHS has been required by a number of courts to afford hearings in disability cases within a specified period of time, thereby causing a "major disruption" in the administration of the HHS hearing process.[47] The number of hearing requests filed with HHS in disability and other cases was recently estimated to have been 275,000 in fiscal year 1981, and it is projected that this number will increase to 340,000 in fiscal year 1982 and to 416,000 in fiscal year 1983.[48] This rapidly expanding caseload even has led to proposals to use *non*-ALJ hearing examiners to hear cases in which Congress heretofore has provided for hearings by ALJs.[49]

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[45] In 1978, for example, 3,899 hearings were requested under Part A and 20,120 were requested under Part B. Defendants' Appendix, *supra* note 16, at 620-621.

[46] See *Subcomm. on Social Security of the House Comm. on Ways and Means, Social Security Hearings and Appeals: Pending Problems and Proposed Solutions*, 97th Cong., 1st Sess. 2 (Comm. Print 1981).

[47] Committee Print, *supra* note 46, at 8. See, *e.g.*, *Blankenship* v. *Secretary, HEW*, 587 F.2d 329 (6th Cir. 1978), on remand, 517 F. Supp. 77 and 522 F. Supp. 618 (W.D. Ky. 1981); *Barnett* v. *Califano*, 580 F.2d 28 (2d Cir. 1978); *White* v. *Mathews*, 559 F.2d 852 (2d Cir. 1977), cert. denied, 435 U.S. 908 (1978); *Caswell* v. *Califano*, 583 F.2d 9 (1st Cir. 1978).

[48] Committee Print, *supra* note 46, at 1, 36-37. More recent statistics compiled by HHS show that the actual number of hearings conducted in fiscal 1981 was 281,737 and that the number of pending cases was 128,764, an all-time high. See Office of Hearings and Appeals, *Key Workload Indicaters* 1 (Nov. 20, 1981). See also Skoler Affidavit, *supra* note 6, at 7-8.

[49] Committee Print, *supra* note 46, at 5-6; H.R. Rep. No. 97-251, 97th Cong., 1st Sess. 80 (1981). Such a provision was deleted from

Especially in these circumstances, the district court's interference with Congress' and the Executive's allocation of scarce governmental personnel and resources in the administration of social welfare programs is wholly unwarranted.

Thus, a consideration of each of the factors in the three-part test announced in *Mathews* v. *Eldridge* weighs heavily against the district court's conclusion that the Due Process Clause requires the Secretary to afford Part B claimants an opportunity for a hearing by an ALJ in HHS.

CONCLUSION

The judgment of the district court should be reversed.

Respectfully submitted.

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DECEMBER 1981

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the HHS appropriations bill on the House floor (127 Cong. Rec. H7061-H7062 (daily ed. Oct. 6, 1981)), but with the understanding that the Social Security Subcommittee of the Ways and Means Committee would study the issue.

APPENDIX

42 U.S.C. 1395u provides in pertinent part:

§ 1395u. Use of carriers for administration of benefits

(a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1395h of this title are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1) (A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

(B) receive, disburse, and account for funds in making such payments; and

(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

(2) (A) determine compliance with the requirements of section 1395x(k) of this title as to utilization review; and

(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1395x(k)(2) of this title) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this part; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.

(b)(1) Contracts with carriers under subsection (a) of this section may be entered into without regard to section 5 of title 41 or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is

reasonable cost (as determined under action 1395x(v) of this title);

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policy holders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1395gg(f) of this title) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1395y of this title, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter (except in the case of physicians' services and ambulance service furnished as described in section 1395y(a)(4) of this title, other than for purposes of section 1395gg(f) of this title);

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an oportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; and

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person fur-

nishing such services, as well as the prevailing charges in the locality for similar services.

* * * * *

(4) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

* * * * *

(c) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract.

(d) Any contract with a carrier under this section may require such carrier of any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(e) (1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

(f) For purposes of this part, the term "carrier" means—

(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

(2) with respect to providers of services only, any agency or organization (not described in paragraph (1)) with which an agreement is in effect under section 1395h of this title.

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☆ U. S. GOVERNMENT PRINTING OFFICE: 1981 388897 725

Appellee's Brief

FILED
JAN 27 1982
ALEXANDER L. STEVAS,
CLERK

No. 81-212

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES,
Appellant,

vs.

WILLIAM McCLURE, CHARLES SHIELDS, and "ANN DOE", individually and on behalf of a class of persons similarly situated,
Appellees.

On Appeal from the United States District Court For the Northern District of California

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QUESTIONS PRESENTED

1. Whether the claims appeal procedure of Part B of the Medicare program provided by 42 U.S.C. § 1395u(b)(3)(C), which vests final, unreviewable decision-making power in a hearing officer who is appointed by and serves at the will of the same private insurance carrier who has previously denied the claim violates the Due Process Clause of the Fifth Amendment of the United States Constitution.

2. If so, whether the appropriate relief is to make available to persons who have received unfavorable Part B hearing officer decisions a further hearing by the Social Security Administration, conducted pursuant to the existing hearing procedures for Medicare Part A claims.

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No. 81-212

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1981

RICHARD S. SCHWEIKER, SECRETARY OF
HEALTH AND HUMAN SERVICES,
Appellant,

vs.

WILLIAM McCLURE, CHARLES SHIELDS, and "ANN DOE",
individually and on behalf of a class of
persons similarly situated,
Appellees.

On Appeal from the United States District Court
For the Northern District of California

BRIEF FOR THE APPELLEES

STATEMENT

I

DESCRIPTION OF THE MEDICARE PROGRAM

This appeal presents a constitutional challenge to the administrative hearing procedures for determining claims under Part B of the Medicare Act, 42 U.S.C. §§ 1395j-w, ff. The Medicare statute delegates final, unreviewable decision-making power to hearing officers who are appointed by and who serve at the will of the same private insurance carrier who has previously denied the claim. Finding that a Part B

hearing officer's "impartiality is subject to doubt,"[1] the United States District Court for the Northern District of California held that "Medicare Part B beneficiaries are entitled to have final determinations made with respect to their claims by hearing officers who are independent of the Medicare carriers." J.S. 21a. To implement its decision the district court ordered that beneficiaries receiving unfavorable decisions shall be entitled to a *de novo* hearing of record conducted by an Administrative Law Judge [hereinafter "ALJ"] of the Social Security Administration. J.S. 24a.[2]

The federal Medicare program enacted in 1965 provides health insurance benefits to persons 65 years of age or older and to disabled persons. Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* The Secretary of Health and Human Services [hereinafter "the Secretary"] is charged with overall program administration.[3]

The Medicare program is divided into two parts. Part A provides primarily for institutional care such as hospitalization and nursing home services. It is financed in the same manner as Social Security retirement benefits, through payroll deductions. Part B covers non-institutional medical

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[1]Jurisdictional Statement [hereinafter "J.S."] at 18a. The district court's opinion is reproduced at J.S. 1a-19a; the district court's Summary Judgment and Order appear at J.S. 20a-23a.

[2]The district court's Order Approving Plan for Implementation of Judgment appears at J.S. 24a-30a; its Final Judgment is reproduced at J.S. 34a-37a.

[3]On May 4, 1980, the Department of Health and Human Services [hereinafter "HHS"] took over the functions pertinent to this action from the former Department of Health, Education and Welfare.

benefits including doctors' fees, ambulance bills, medical supplies, x-rays, laboratory tests, and physical therapy. Part B benefits, in contrast with Part A benefits, are financed both through monthly premiums paid by the enrollees and through general revenue funds. Consequently, the Part B program is very similar to a private insurance program.

However, the Secretary's characterization of the Part B program as a "*voluntary* program of supplementary medical insurance . . . that the individual beneficiary is free to opt out of . . . and purchase a comparable private insurance plan" is misleading. Brief for the Appellant [hereinafter "HHS Br."] at 46. Although the program is voluntary, in the sense that no beneficiary is coerced into joining, private coverage is not available at a comparable cost. The Part B premium through June 30, 1981 of $9.60 per month was far less than one would pay without federal financing, specifically, $32.60 for the aged and $51.00 for the disabled. National Commission on Social Security, Final Report, *Social Security in America's Future* 261 n.3 (March 1981). Moreover, the Secretary, by simply asserting that comparable coverage is available, overlooks both the practical problems that the high-risk elderly and disabled would have in finding health insurance coverage, and the fact that most private policies contain exclusions, such as those for preexisting medical conditions.

Similarly, although the Part B program is entitled "Supplementary Medical Insurance" it is in fact a program which provides for basic health care services. No health service is as basic as physician's services, which are cov-

ered under Part B. Indeed it is improbable that one would incur hospitalization charges under Part A without also incurring charges for a physician's services under Part B.

Therefore, it is not surprising that enrollment in Part B is only slightly smaller than that of Part A.[4] Indeed, a 1972 amendment to the Medicare program provided that persons who become eligible for Part A are automatically enrolled in Part B as well, unless they take some affirmative steps to decline enrollment before coverage starts. 42 U.S.C. § 1395p; 42 C.F.R. § 405.210(b).

The Medicare program does not pay all health care costs of the elderly or disabled. Rather, the statute specifically excludes certain categories from its coverage, such as dental care, eyeglasses, hearing aids, and preventive services. 42 U.S.C. § 1395y. In addition, the statute imposes certain general requirements on services to be covered, including that they must be medically necessary and that physicians' allowable charges can be no higher than "reasonable". 42 U.S.C. §§ 1395u(b)(3), y.

Both parts of the Medicare program are administered by private entities, usually insurance companies, called intermediaries (under Part A) or carriers (under Part B), under contracts with the Secretary. 42 U.S.C. § 1395u(a).

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[4] According to 1979 Health Care Financing Administration statistics, there were 27,858,742 persons enrolled in either Part A or Part B, which included 27,459,157 enrolled in Part A and 26,757,329 enrolled in Part B. Health Care Financing Administration, Office of Research, Demonstrations, and Statistics, U.S. Department of Health and Human Services, *Health Care Financing Notes: Persons Enrolled for Medicare, 1979*, Table 1 (HCFA Pub. No. 03079, January 1981).

Part B carriers are awarded contracts to provide Medicare program administration in specific geographical areas. For example, Blue Shield of California, a defendant in the instant action, administers the Part B program in the Northern California area.[3]

Medicare claims may be submitted either by the beneficiary or by the provider of medical services, if the beneficiary has "assigned" the claim to a provider. Claims are submitted directly to the carrier, who is charged with making an "initial determination" to pay the claim, to reduce it in part, or to deny it in full. 42 U.S.C. §§ 1395u(b)(3)(C), ff; 42 C.F.R. §§ 405.702, 405.803. Thus, the private carrier must determine whether the services were covered by Part B, whether they were medically necessary, and whether the charge for the services was reasonable.

If a claimant is dissatisfied with the initial determination, he or she then has the opportunity for a paper review or reconsideration by the same insurance company that rendered the initial determination. Following the insurance company's in-house review or reconsideration, the claimant who remains dissatisfied is entitled to a hearing, but only if the amount at issue is $100 or more. 42 U.S.C. §§ 1395u(b)(3)(C), ff(b)(2).

At this stage, the type of hearing and subsequent procedures begin to differ depending on whether the claim arises under Part A or Part B of the Medicare program. Under Part A the hearing is held before a Social Security Administration ALJ. If the claimant desires, review of the hearing decision can be sought in the Social Security Ap-

[3]Blue Shield of California has not appealed the judgment below.

peals Council, and ultimately, if the amount in controversy is $1,000 or more, judicial review is available in the federal court system. If the claim arises under Part B, the hearing is held by a hearing officer provided by the insurance company, and is final without the possibility of further review. 42 U.S.C. §§ 1395ff(b)(1)-(2).[6]

It should be noted at the outset that Part B appeals are rarely used by Medicare beneficiaries. Consequently, only a small fraction of the claims require a hearing conducted by insurance carrier-appointed hearing officers. For example, in 1978, out of 125 million claims, only 1.2% of the claimants asked for "review", where a second carrier employee re-examines the initial determination of the claim without holding any hearing. Of the Part B claims that were reviewed in 1978, approximately 1.5 million nationally, only 20,120, or 1.4%, of the claimants who requested review subsequently requested hearings, and of those, 7,301 requests were dismissed or withdrawn without a hearing. Attachment B to Affidavit of Stanley Katz, Joint Appendix [hereinafter "J.A."] at 45.

A few additional facts must be noted. First, both Part A and Part B hearings concern claims of varying amounts since the $100 jurisdictional limit exists for both programs. Second, Part A cases often raise issues that will also arise in Part B hearings. Many medical procedures lead to both Part A (hospital bills) and Part B (physician's fees) claims being filed. The resolution of these claims consequently depends on common factual and/or legal determi-

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[6]Claims concerning eligibility for the Part B program itself receive Part A hearing rights. 42 U.S.C. § 1395ff(b)(1)(B).

nations. For example, the issue of whether the entire medical procedure is medically necessary as required by 42 U.S.C. § 1395y(a)(1) is a common issue in appeals under both programs. Third, the payments involved in Part B cases may often concern life-saving medical procedures. For example, physician's fees for major surgery would be included in a Part B claim. Finally, Part B hearings can be extremely complex, involving difficult medical and legal questions. Consequently, hearing officers must possess considerable skill.

II

PROCEEDINGS BELOW

The case *sub judice* is a nationwide class action commenced in the United States District Court for the Northern District of California challenging the Part B hearing procedures as a violation of the Due Process Clause of the Fifth Amendment. The suit was filed in February 1979 by three named plaintiffs whose claims for Part B benefits were denied by hearing officers. The district court certified a class consisting of "all persons who have received Medicare Part B hearing officer decisions dated on or after May 1, 1980, in which coverage of benefits has been wholly or partly denied." J.S. 35a.[7]

On cross-motions for summary judgment, the district court held that the due process rights of Medicare beneficiaries under the United States Constitution are violated by the Medicare Part B hearing system. J.S. 18a. In reach-

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[7]Excluded from the class were "persons who are plaintiffs in other actions currently pending against the Secretary of Health and Human Services which raise issues similar to those raised herein." J.S. 35a.

ing its conclusion the district court stressed the three unique characteristics of the Part B hearing system which make it a radical departure from traditional notions of fair procedure in the operation of a decision-making tribunal.[8] First, there is a statutory delegation of adjudicatory decision-making not to an administrative agency, but to a private insurance company which holds a government contract. Second, the hearing officer's decision is not subject to appeal to either the Secretary or the courts. Third, the hearing officer, whose function is to review a claim which the carrier has twice denied, is appointed by that same carrier and serves at its will, without any protection whatsoever against retaliatory dismissal or assurance of being allowed to serve in the future.

Having declared the Part B hearing procedures unconstitutional, the court suggested certain options[9] and directed the parties to present proposals for relief. J.S. 16a, 20a-23a. After the submission of plans, the court ordered that persons who were dissatisfied with the decisions of the insurance company hearing officers could, if the amount in controversy were at least $100, request a hearing *de novo* before an ALJ. J.S. 36a-37a. In sum, the court first found a violation of due process and it later attempted to cure the problem by ordering ALJ hearings. Thus, the Secretary seriously mischaracterizes the district court holding by claiming that this case presents but one issue. HHS Br. at

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[8]A more detailed discussion of the district court's decision is presented in Sections I-III of the Argument, *infra*.

[9]Relief will be discussed in greater detail in Section IV of the Argument, *infra*.

I. The district court did not hold that due process was violated because Part B procedures do "not provide for a hearing before an Administrative Law Judge." *Id.* Rather, its inquiry was twofold: (1) does the system violate due process? and if so, (2) what is the appropriate relief?

The Secretary's motion for a stay pending direct appeal to this Court was subsequently denied by the district court. J.S. 38a-40a. However, on June 12, 1981, Justice Rehnquist ordered the district court's orders stayed pending judgment of this Court. J.S. 44a-45a.

SUMMARY OF ARGUMENT

The district court held unconstitutional the hearing procedures for determining claims appeals under Part B of the Medicare program. It based its decision on two interrelated due process grounds: (1) that the hearing officers who are appointed by the private carriers administering Part B of the Medicare program are not impartial decision makers, and (2) that the vesting of final, unreviewable adjudicatory power in these hearing officers represents an unconstitutional delegation of governmental authority. Appellees, William McClure, *et al.*, a nationwide class of Medicare beneficiaries [hereinafter "the Medicare beneficiaries"] submit that this decision was correct and should be affirmed.

1. The district court is not alone in its condemnation of Part B procedures. In 1980 the American Bar Association House of Delegates concluded that "under the current procedure there can be no truly 'fair' hearing since the hearing officer is engaged by the carrier who rendered

the initial adverse determination. . . . [I]t is unreasonable to expect the hearing officer to be impartial." *See* p. 16 *infra*. Similarly, the National Commission on Social Security, charged by Congress with reviewing the Medicare Act, found that "[f]inal decision-making authority should not be given to an individual [the Part B hearing officer] whose impartiality could be compromised because of association with the carrier whose decision is being appealed." *See* p. 17 *infra*.

At the outset, it must be understood that private insurance carriers are not neutral decision makers interested only in paying just claims. Rather, they are private corporations desirous of acquiring and retaining Medicare contracts to further their financial interest. The Secretary, charged with protecting the public fisc, is concerned with containing the costs of the Medicare program, and carriers are necessarily mindful of HHS directives aimed at minimizing costs.

In light of the carriers' cost-saving mandate, it is necessary to consider the extent to which hearing officers can maintain their independence from the carriers whose decisions they review. They are employed on a hearing-by-hearing basis, compensated in an amount set by the carrier, and subject to discharge at any time, without reason and without recourse. Since their salary depends totally on how often they are called upon to review carrier decisions, they must of necessity stay within the carrier's good graces. Obviously, their independence must be compromised by such an arrangement.

Selection of hearing officers is left up to the carriers, limited only by vague HHS guidelines. HHS does not monitor individual selection or discharge decisions. Positions are rarely advertised, and often go to current or former carrier employees who have a long association with the company.

HHS does little to ensure the quality of hearing officer decision-making. Instead, training of the hearing officers is done primarily by the carriers. There is no requirement that hearing officers be lawyers, and most of their training is by non-lawyers. It is therefore doubtful that hearing officers will develop the judicial independence and skills necessary for making final decisions on claims under a complex federal law. Moreover, carriers have no expertise in conducting hearings, because that is not a part of their business, aside from their Medicare contracts. Finally, no appeal is allowed which might serve as a quality control.

2. In light of these facts, the district court held that "the Part B hearing procedures violate plaintiffs' due process rights insofar as the final, unappealable decision regarding claims disputes is made by carrier appointees whose impartiality is subject to doubt." J.S. 18a. This decision fully comports with this Court's frequent admonition that "justice must satisfy the appearance of justice." *In re Murchison*, 349 U.S. 133, 136 (1955). Part B procedures fail to meet this standard for two separate reasons: the prior involvement of the hearing officer and the officer's pecuniary interest in the case.

There is a close connection between the hearing officer and the carrier, as evidenced by the hiring, termination,

and training process. Moreover, the carrier has already twice denied the claim under review. Thus, in order to rule in favor of a claimant the hearing officer must directly reverse the earlier decisions of fellow insurance company personnel, possibly reversing his own supervisors.

The hearing officer has been so closely involved with, and dependent on, the carrier whose decisions he reviews that he is tempted to uphold the carrier's policies regardless of their correctness. This prior involvement between the hearing officer and the carrier presents an appearance of bias. By way of analogy, it is inconceivable that a federal judge, with full judicial independence, would be allowed to review a decision made by an entity with a similarly close present or past association. Indeed, the district court observed that federal judges often disqualify themselves from cases involving their former law firms even as to matters that arose after the judge left the firm. The district court correctly concluded that it was improper to apply a more lax standard to non-tenured Part B hearing officers, whose decisions are final and unreviewable. J.S. 10a.

The other source of bias is the pecuniary interest of hearing officers. As carrier employees without job security, they must remain in the carrier's good graces in order to have some assurance of future employment. This situation presents an inevitable temptation to uphold the carrier's prior decision.

The Secretary claims that no *actual* bias has been shown. HHS Br. 30, 35. However, the relevant question is whether there is an *appearance* of bias. Since an appearance of

bias inevitably results from the relationship between the carriers and the hearing officers, Part B procedures cannot satisfy this Court's due process standards.

3. The second basis for the district court's holding is that the vesting of final decision-making power in carrier-appointed hearing officers rather than in an independent tribunal violates due process. This conclusion accords with a number of decisions holding that the delegation of such governmental adjudicatory functions to a private entity must be accompanied by a right of appeal. These decisions are to be contrasted with delegations to *governmental* entities where review is less necessary.

The district court reached its conclusion by utilizing the test stated in *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976). The court first examined the private interest of the Medicare beneficiary in being compensated for his medical bills. Unpaid medical bills can present enormous problems for the aged and infirm, as Congress recognized when it created the Medicare program. Even if the beneficiary has supplementary private insurance coverage, loss at a Part B "fair hearing" is likely to lead to an uninsurable out-of-pocket loss.

The district court then considered the second prong of the *Eldridge* test: the risk of an erroneous deprivation of benefits and the value of additional procedures. Medicare beneficiaries risk the permanent loss of benefits, in contrast with the situation in *Eldridge*, where benefits were simply delayed. Further, because hearing officers' qualifications are left up to the discretion of the carriers, without any

specific criteria that would ensure knowledge of the law, the district court was clearly correct in finding that an additional review would be of value.

Third, the district court, in accord with *Eldridge*, assessed the governmental interest at stake. One clear governmental interest is to "convey to the individual a feeling that the government has dealt with him fairly." *Carey v. Piphus*, 435 U.S. 247, 262 (1978). Clearly, the present procedures, which the informed public as well as the district court has discredited, do not satisfy this governmental interest. Further, as explained below, the cost of assuring the integrity of the Part B hearing procedures is modest when compared with the massive size of the Part B system. Thus, the governmental interest supports the establishment of hearing procedures which comport with fundamental fairness.

The considerations set forth by this Court in *Eldridge* therefore compel the conclusion reached by the district court that the due process rights of Medicare beneficiaries can be protected only by making available an appeal to the Secretary from Part B hearing decisions.

4. To remedy the due process violations the district court ordered the simplest and most equitable relief possible: *de novo* review by Administrative Law Judges (ALJs) employed by the Social Security Administration. These ALJs already hear Medicare Part A cases, and are tenured, experienced attorneys. Their independence from the carriers assures their freedom from bias.

The court's order does not create a new bureaucracy, nor does it require a change in the internal workings of

the carrier appeals system. It simply adds a layer of appeal to that system. The relief also provides, for the first time, continuity in decision-making in Medicare appeals, since common issues that arise in Part A and Part B components of a given claim can now be resolved by the same tribunal.

Unpaid medical bills are a severe problem for the elderly and infirm. It is thus essential that fair procedures exist for determination of Medicare coverage. Due process requirements are violated when hearing officers are not impartial and no appeal is allowed. Therefore, the district court's judgment should be affirmed.

ARGUMENT

I

THE PART B HEARING SYSTEM IS SERIOUSLY FLAWED

A. Introduction

In this argument the Medicare beneficiaries will show that the Part B hearing officer system violates the Due Process Clause of the Fifth Amendment of the United States Constitution. The district court correctly reached this conclusion on two grounds: (1) that Part B hearing officers are not impartial decision makers and (2) that the unavailability of any independent, administrative review of carrier-appointed hearing officers' decisions represents an unconstitutional delegation of governmental power. The district court was not alone in its assessment of the Part B hearing procedures, as the inadequacies of these procedures have been noted by a number of informed organizations. For example, on August 6, 1980 the American Bar Associa-

tion House of Delegates adopted a report and recommendations calling for reform of the Part B hearing procedures:

> The only review of adverse determinations by carriers regarding Part B claims that is prescribed under the Medicare Act is the so-called "fair hearing" required to be offered by carriers with respect to controversies involving amounts in dispute of $100 or more. 42 U.S.C. § 1395u(b)(3)(C). As a practical matter, under the current procedure there can be no truly "fair" hearing since the hearing officer is engaged by the carrier who rendered the initial adverse determination. Under these circumstances, it is unreasonable to expect the hearing officer to be impartial.

ABA Report on Medicare Appeal Procedures, in *Medicare & Medicaid Guide* ¶ 30,608, at 10485, 10488 (CCH, 1980 Transfer Binder).

Similar conclusions have been reached by the National Commission on Social Security, an independent, bipartisan panel charged by Congress with reviewing all aspects of Social Security law. 42 U.S.C. § 907. In its final report, submitted to the President and Congress on March 12, 1981, the Commission roundly condemned the relationship between the carrier and its hearing officers:

> If the amount at issue in an entitlement claim is at least $100, a beneficiary dissatisfied with the carrier's award may request a hearing by an officer appointed by the carrier. Hearing officers may be disqualified upon a showing of prejudice, partiality, or interest in the matter. Although HCFA [HHS's Health Care Financing Administration] sets out very general selection criteria for these hearing officers, it does not review their qualifications. There is no nationwide uniformity in selection and training procedures.

> Final decision-making authority should not be given to an individual whose impartiality could be compromised because of association with the carrier whose decision is being appealed (footnote omitted). *The Commission recommends that hearings involving coverage of services under the SMI [Part B] program be conducted by employees of the Federal government, under rules to be established by the Secretary.*

National Commission on Social Security, Final Report, *Social Security in America's Future* 278 (March 1981). We now turn to the facts which have led to this criticism of Part B procedures.

B. Private Carriers Have a Stake in the Decision-Making Process

In order to understand the enormous potentiality for bias in Part B hearing officer decisions, the relationship between the Secretary and the insurance carriers must be considered first. HHS has built into its system for administering the Medicare program a number of cost-saving devices which instill in the private carriers a sense of the importance of conserving Medicare program money. As a consequence, private carriers are not neutral decision makers who are interested only in paying just claims. Rather, they have a stake in the outcome of the decision-making process.

Cost-saving devices are directed squarely at reducing the amounts of program money paid out to beneficiaries by carefully guarding against the payment of claims for services considered to be unauthorized under a strict construction of the Medicare statute. For example, the

"PARE" program consists of a campaign to help selected carriers identify providers of medical services who give more services than HHS believes are "medically necessary," so as to scrutinize more closely claims based on their services. Plaintiffs' Appendices to Memorandum of Points and Authorities in Support of Motion for Summary Judgment, filed November 30, 1979 [hereinafter "Plaintiffs' Appendix"] 201-03, Docket No. 38. Warnings about controlling overutilization of services dominate the instructional material given to providers and the annual reviews of carriers' performance (ACERs). Plaintiffs' Appendix 190-96, Docket No. 38. Consequently, a significant portion of Medicare administrative costs is spent on reducing amounts paid to beneficiaries, because of the expense of "controlling overutilization" and reducing "reasonable charges." For example, the 1976 statement of administrative costs of carrier Blue Cross of New York shows that it spent a total of $1,312,063 in connection with attempts to reduce the amount paid as benefits.[10]

The carriers, in making payments on Medicare benefits, will refer to the manner in which they pay claims as private insurers. Indeed the Medicare Act specifically uses their reimbursement policies as a ceiling for Medicare benefit payments. 42 U.S.C. § 1395u (b)(3)(B). It cannot be denied that the carriers have an incentive to be cautious in making payments on claims on their own policies because of their

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[10] "Utilization and reasonable charge review," at line 2, Plaintiffs' Appendix 204, Docket No. 38.

need to turn a profit, and that these same policies will be followed on Medicare claims.[11]

Some of this cost-saving impetus is also directed toward reducing administrative expenses, evidenced by extensive annual negotiations and reviews of each carrier's operating budget; the lengthy attention given to efficiency and cost-saving procedures in the Annual Contractor Evaluation Reviews (ACERs) performed by regional offices of HHS; and the attention to administrative cost-saving in periodic audits of the carriers conducted by the HHS Regional Audit Agency.[12]

Moreover, recent changes in the method of payment to carriers provide a further incentive for containment of administrative costs. Carriers have been generally compensated for their actual costs. However, the Secretary is authorized to enter into fixed-cost contracts and has begun using them in various locations. 42 U.S.C. § 1395b-1. Competitive bidding for these fixed-cost contracts is yet another reminder to the carriers that they risk loss of their contracts if they do not contain program costs. *See Health Care Service Corp. v. Califano,* 601 F.2d 934 (7th

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[11]The Medicare beneficiaries do not dispute the integrity of private carriers in administering their own policies. This integrity is safeguarded by the availability of independent review by arbitration and by the courts. When similar problems arise on a Medicare claim, however, no independent review is allowed.

[12]*See* Plaintiffs' Appendix 190-98, Docket No. 38; HEW Answers to Interrogatories in *Gadsden v. Califano,* No. CV 75-2946 ALS (C.D. Cal., filed Aug. 29, 1975), Interrogatories 20-21, in Defendants' Appendix 2 to Reply to Memorandum of Points and Authorities in Support of Motion for Summary Judgment, filed December 31, 1979, [hereinafter "Defendants' Appendix"], 471-74, Docket No. 48.

Cir. 1979), *aff'g* 466 F.Supp. 1190 (N.D.Ill. 1979); *Blue Cross Association v. Harris,* 622 F.2d 972 (8th Cir. 1980); *Blue Cross Association v. Harris,* No. 80-1044 (10th Cir., Nov. 20, 1981); HEW News, HEW-I79, for release May 2, 1978, Plaintiffs' Appendix 199-200, Docket No. 38.

Carriers have a financial interest in retaining their Medicare administration contracts, notwithstanding the fact that their services are technically "non-profit." There are several ways in which insurance companies further their interests by acting as carriers. One "has to do with economies of scale: if a firm can achieve greater economies in expanding its volume of business by taking on a Medicare clientele, then it will do so."[13] Another is the opportunity to "maximize administrative costs" paid by Medicare so "they can become more competitive in their regular business by allocating as much of their regular business administrative costs as possible onto Medicare administrative costs. . . ."[14]

In addition, Jack C. Byrne, an officer of Occidental Life Insurance Company in Los Angeles, California, stated the advantages of being a carrier as follows:

> Well, first from a PR standpoint, our name, Occidental Life, is going out on thousands of checks each month. I think in the original bidding we were also interested as a private carrier, carrying health and accident insurance in that we stay in touch with the health care problems and health and accident insurance in general, and with the probable advent of national

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[13]R.D. Blair & R.J. Vogel, *The Cost of Health Insurance Administration: An Economic Analysis* 144 (1975).

[14]*Id.*

> health insurance, we would want to be involved in that project. . . . Yes, we share the same computer equipment. . . . Yes, I think it gives us the facility of having, perhaps, better equipment.[15]

Because of the foregoing incentives for a private insurance company to become and remain a Medicare carrier, it will comply as fully as possible with HHS' cost-saving imperatives, and attempt to persuade the Secretary that it is guarding the expenditure of federal funds as vigilantly as its own money.

C. Part B Hearing Officers Are Not Independent of the Carrier

Part B hearing officers have no job security whatsoever. They can be fired without cause at any time. In addition, they have no guaranteed income, but perform hearings on a piece-work basis at the discretion of an insurance company employee who supervises the holding of hearings. The amount paid to each hearing officer is set by the carrier. HEW Answers to Interrogatories in *Gadsden v. Califano, supra,* Interrogatory 2, Defendants' Appendix 460-62, Docket No. 48. Since Part B hearing officers lack any sense of permanence they must at all times remain in the carrier's good graces. Furthermore, since there is no system for random assignment of cases among the various hearing officers, a particular hearing officer might receive more or less paid work in a given year for no apparent reason. As the district court observed, their incomes "are

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[15]Deposition of Jack C. Byrne, in *Gadsden v. Califano,* No. CV 75-2946 ALS (C.D. Cal., filed Aug. 29, 1975) [hereinafter "Byrne deposition"], Defendants' Appendix 10-11, Docket No. 48.

entirely dependent upon the carrier's decisions regarding whether, and how often, to call upon their services." J.S. 10a. Thus it would be surprising if hearing officers did not speculate as to whether the content of their decisions affected the assignment of cases to them by the insurance company's personnel. With this in mind, if the insurance company is taking a "cost-saving" position on a particular claim, and has already ruled twice against the claimant on a substantive matter, the temptation for the hearing officer to rule in favor of his supervisor and company to protect his future employment prospects is great.

Moreover, the Part B procedures allow the carrier to request that a hearing officer's decision be "reopened" when the carrier considers the hearing officer to have "exceeded his jurisdictional authority." Although hearing officers have a theoretical right to refuse to do so, their lack of job security provides a temptation for them to comply with such requests. J.A. 40-41.

In addition to the threat of possible termination that is unchecked in the current system, a further related factor creating a taint of bias is the internal selection process for the same hearing officers. This gives the carriers an opportunity to select persons who will not be independent.

The selection of Part B hearing officers is left up to the carriers whose decisions they review. HHS, which directs the carriers' administration of the Medicare program, has provided the insurance companies with extremely vague guidelines for selecting hearing officers. *Carriers Manual* § 12016(B), J.A. 22; *Hearing Officers Handbook* 9, J.A. 47. There is no minimum educational level, nor any require-

ment of legal studies. The Part B hearing officer is not required to be a lawyer, let alone to have a record of experience as an administrative lawyer. J.S. 13a-14a. As a result, the district court concluded that there are "no meaningful, specific selection criteria governing the appointment of hearing officers." J.S. 11a. It noted that, in addition, the Secretary "does not review actual selection decisions to determine whether even these minimal criteria are satisfied." J.S. 11a n.6.

Related to the problem of lack of standards for Part B hearing officers is the fact that the positions are rarely advertised in the community. Rather, a system of recruitment through word of mouth results in the hiring of persons already known to local carrier management.[16] Often these persons are current or former employees of the insurance company itself. Because of the lack of standards for hiring Part B hearing officers, it was possible for defendant Blue Shield of California, a carrier, to reward its retired executives with jobs as Part B hearing officers. The court below noted that "five out of the seven hearing officers appointed by Blue Shield during the history of the Part B program are former *or current* Blue Shield employees." J.S. 10a. Only one of the seven was an attorney. Answers to Plaintiffs' Interrogatories to Blue Shield of California, No. 3, Defendants' Appendix 680-85, Docket No. 48.

Moreover, the carrier hearing officers who review Part B claims decisions by the carrier are employees of the same branch of the carrier that has prepared the evidence for

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[16]Byrne deposition, Defendants' Appendix 12-14, Docket No. 48.

the hearing. Byrne deposition, Defendants' Appendix 6, 12, 19, Docket No. 48. It must be borne in mind that the hearing officers do not simply review the clerical processing of initial claims, but rather all decisions made with respect to claims for which hearings are requested. So, although the hearing officers are prohibited by 42 C.F.R. § 405.824 from ruling on claims in which they have had previous personal involvement, they may be frequently placed in the untenable position of having to review policy decisions of their supervisors.

The lack of training provided Part B hearing officers further impairs their ability to act independently of the carrier. There is little training by HHS, based on a conclusion that "extensive training and frequent training is not needed" for Part B hearing officers despite their unreviewable decision-making power.[17]

The only other training is that done "in-house" by the carriers. But the carrier employees who provide such training are not themselves trained as adjudicators. In addition, this in-house training is often provided by the same insurance company executives (themselves not lawyers) who hire the hearing officers, schedule the hearings, supervise the preparation of the carrier's case prior to the hearing and

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[17]Deposition of Stanley Katz in *Gadsden v. Califano, supra* [hereinafter "Katz deposition"], Defendants' Appendix 281, Docket No. 48. Occasionally HHS conducts training sessions for hearing officers at its national or regional offices, attendance at which is voluntary. *Id.* 217-19. The "training materials" identified by the Secretary consist simply of the *Hearing Officers Handbook*, carrier manuals, Medicare statutes and regulations. HEW Answers to Interrogatories, in *Gadsden v. Califano, supra*, Interrogatories 11-13, Defendants' Appendix 467-68, Docket No. 48.

review the hearing decisions afterward. Their experience with the hearing process is limited to administration of Medicare, as they do not have any hearing function, and have not developed any expertise in hearings in connection with their private insurance policies. Thus, there is no reason to expect a strong sense of independence to develop through this training.

The Secretary argues that it "monitors the carriers' performance . . . through a quarterly review of a sample of the hearings." HHS Br. 23. However, the record indicates that this "review" does little to ensure hearing officer independence from the carrier, for the critiques are sent to HHS regional offices rather than to the carrier or its hearing officers. Thus, Jack Byrne, whose function was to supervise Part B hearing officers for Los Angeles-based Occidental Insurance Company, testified that in an eleven year period, he had never received *any feedback* from the Secretary as part of this sampling process. Byrne deposition, Defendants' Appendix 8, Docket No. 48.

Although the *Carriers Manual* may purport to provide for systematic review of carrier decisions, a recent Government Accounting Office report indicates that the sample in fact selected may be quite small. For example, the Secretary could locate evidence of only 6 of 1351 "fair hearing" decisions by E.D.S. Federal Corporation hearing officers having been reviewed.[18]

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[18]General Accounting Office letter to Rep. Paul Simon, "Review of Alleged Questionable Actions by EDSF to Reduce its Claims and Correspondence Backlogs Under its Medicare Contract in Illinois," 15, Dec. 6, 1980.

Finally, of course, there is no appeal from the Part B hearing officers' decisions that could provide some sort of quality control. Part B hearing officers may make erroneous decisions repeatedly without ever learning about their mistakes from reversals on appeal.

II

THE DUE PROCESS MANDATE OF AN IMPARTIAL TRIBUNAL IS VIOLATED BY THE PART B HEARING SYSTEM

This Court has long recognized that, as a fundamental requirement of our system of justice, a decision making tribunal must be an impartial one. "A fair trial in a fair tribunal is a basic requirement of due process. Fairness of course requires an absence of actual bias in the trial of cases." *In re Murchison*, 349 U.S. 133, 136 (1955). The requirement of impartiality applies to administrative proceedings as well as to formal judicial proceedings. *Gibson v. Berryhill*, 411 U.S. 564, 579 (1973). In applying the requirement, this Court has explained that due process prohibits not only proven bias, but also the appearance of bias.

> [O]ur system of law has always endeavored to prevent even the probability of unfairness. To this end no man can be a judge in his own case and no man is permitted to try cases where he has an interest in the outcome. That interest cannot be defined with precision. Circumstances and relationships must be considered. This Court has said, however, that "every procedure which would offer a possible temptation to the average man as a judge . . . not to hold the balance nice, clear, and true between the State and the accused denies the

> latter due process of law." *Tumey v. State of Ohio*, 273 U.S. 510, 532. Such a stringent rule may sometimes bar trial by judges who have no actual bias and who would do their very best to weigh the scales of justice equally between contending parties. But to perform its high function in the best way "justice must satisfy the appearance of justice." *Offutt v. United States*, 348 U.S. 11.

In re Murchison, 349 U.S. at 136.

In this case the district court concluded that "the Part B hearing procedures violate plaintiffs' due process rights insofar as the final, unappealable decision regarding claims disputes is made by carrier appointees whose impartiality is subject to doubt." J.S. 18a.

Two forms of bias in a decision maker that have been repeatedly condemned by the courts are prior involvement and pecuniary interest. Either of these kinds of bias standing alone would destroy the impartiality of a tribunal and for that reason constitute a violation of due process. In this case the district court held that both of these sources of bias exist in Part B hearing officers: "their impartiality is compromised by virtue of both prior involvement and pecuniary interest." J.S. 9a.

A. The Prior Involvement of the Hearing Officer Who is Employed by the Carrier Creates Unconstitutional Bias

In assessing the risk of bias arising from prior involvement of the decision maker, this Court has indicated that it is appropriate to consider, when a class of decision makers has also initiated the filing of the proceeding,

whether those adjudicators "would be so psychologically wedded to their complaints that they would consciously or unconsciously avoid the appearance of having erred or changed position." *Withrow v. Larkin*, 421 U.S. 35, 57 (1975). Akin to this is the situation where an individual must rule not on his own prior decision, but on the decision of his employer. This situation may pose a risk that the decision maker will consciously or unconsciously lean towards upholding the employer to prevent possible undesirable repercussions. This carries particular force in the Part B system, where hearing officers do not have job security, such as tenure, or fixed hours or wages. Whereas it may be assumed that a governmental employee with job tenure does not face this dilemma, and is therefore entitled to a "presumption of honesty and integrity," that is not the case with Part B hearing officers.[19]

A useful analogy in this context is that prior involvement of federal judges has long been recognized as raising the specter of partiality. Consonant with the long-standing admonitions of the Canons of Judicial Ethics, 28 U.S.C. § 455(a), enacted in 1974, requires that a justice,

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[19]See *Withrow v. Larkin*, *supra*, *id.* at 47, concerning a state board of medical examiners. *FTC v. Cement Institute*, 333 U.S. 683 (1948), the Federal Trade Commission; *NLRB v. Donnelly Garment Co.*, 330 U.S. 219 (1947), a trial examiner for the National Labor Relations Board. In *Richardson v. Perales*, this Court rejected a constitutional attack on the impartiality of Social Security Administration hearing examiners, based in part on an assessment of the "governmental structure" involved, 402 U.S. 389, 410 (1971). As discussed in Section III *infra*, private decision makers, such as Part B hearing officers, have not been accorded the same deference by the courts as have administrative agencies, with respect to due process considerations.

judge or magistrate of the United States "shall disqualify himself in any proceeding in which his impartiality might reasonably be questioned." The district court observed that, heeding this admonition, many judges routinely disqualify themselves from "any matters in which their former law office is involved, whether or not the particular matter was pending before the judge left the firm." J.S. 10a.

Moreover, it has been held that it is important to have the highest standards of impartiality when non-judges assume adjudicatory functions. *See Commonwealth Coatings Corp. v. Continental Casualty Co.*, 393 U.S. 145, 148-49 (1968) (arbitrator); *NLRB v. Phelps*, 136 F.2d 562, 563 (5th Cir. 1943) (administrative agency trial examiner).

The Secretary attempts to distinguish the present situation from the practice of judges with respect to their law firms by asserting that carriers and their employees are not "advocates." HHS Br. 36-37. The assertions in the *Carriers Manual* cited in support of this claim do not, of course, necessarily reflect realities in practice.[20] Moreover, whether or not it is appropriate to describe the carrier as an advocate, it is inconceivable that a judge could be called on to review a decision made by an entity with as much discretionary power over him as the private Medicare carriers have over their hearing officers. Thus, the district court was clearly justified in concluding:

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[20] *Compare* Byrne deposition, Defendants' Appendix 45, Docket No. 48 *with Carriers Manual* § 12020, J.A. 31-32, § 12016(B), J.A. 22.

> To apply appreciably more lax standards to hearing officers whose final decisions, unlike those of most judges, are appealable to no other tribunal, poses a constitutionally-unacceptable risk of decisions tainted by bias.
>
> J.S. 10a.

The uncontested record here indicates the presence of numerous factors creating a taint of bias. First, as noted above, the hearing officers are chosen by the carriers without any specific standards or selection process imposed by the Secretary. This often results in the hiring of persons with a strong allegiance to the carrier: present or retired executives of the insurance company. Second, Part B hearing officers have no tenure and hold their positions at the pleasure of the carrier. They often work part-time on a case by case basis, with the number of cases assigned to them varying from time to time at the discretion of the carrier. Third, the carrier executive who determines when an individual hearing officer is called to handle cases also is responsible for the training of that hearing officer and the preparation of the case under review. It must be remembered that the carrier is not only preparing the case for the hearing but has also already twice considered and denied the beneficiary's claim, once at the initial determination and again at the reconsideration-review. Thus, in order to rule in favor of a claimant, the hearing officer must directly reverse the earlier decisions of his fellow insurance company personnel at two different levels, possibly reversing his supervisors. The district court correctly found that all these factors together contravened the constitutional requirements of impartiality. J.S. 11a.

B. Part B Hearing Officers Have a Pecuniary Interest Which Prevents Them From Serving as Impartial Decision Makers

A second source of bias in decision-making is pecuniary interest of the hearing officer. This principle was first enunciated in cases where the interest was direct, but has also come to apply where the interest is indirect. In *Tumey v. State of Ohio*, 273 U.S. 510 (1927), it was held that a combination mayor-judge whose salary as judge was paid out of fines that he imposed and who was, as mayor, responsible for the financial soundness of the city, was not an impartial tribunal as required by due process. More recently, in *Ward v. Village of Monroeville*, 409 U.S. 57 (1972), this Court held that the constitutional test was not met by a mayor-magistrate who could order fines payable to the village, while he was also responsible for its finances as mayor. In that case, there was no showing that the decision maker benefitted personally from the outcome of the case. The proscribed pecuniary interest was merely the magistrate's general sense of concern, as a village official, for its financial well-being. In *Gibson v. Berryhill*, 411 U.S. 564 (1973), this Court held that a group of opticians engaged in private practice who were sitting on the Alabama Board of Optometry could not satisfy the impartiality requirement of due process with respect to adjudicating charges of unprofessional conduct brought against optometrists working for a corporation, a form of practice allegedly in violation of state law. There, the actual financial interest of the board members, none of whom worked for a corporation, in the discontinuation of a different type of optometric practice was speculative;

no particular financial gain or loss to an individual board member could be said to result from their decisions. Nevertheless, this Court found the Board to be biased. *See also Connally v. Georgia*, 429 U.S. 245 (1977).

While the Part B hearing officers do not profit directly from a hearing decision affirming the denial of a Medicare claim, they do have indirect financial incentives for ruling in favor of the carrier. As carrier employees, they are aware of the great cost-consciousness in the Medicare program and the consideration that this must receive in determining whether their employer will retain its Medicare contract. *See* Section IB, *supra*. As employees and subcontractors of the carrier, the hearing officers have a stake in its financial well-being.

Financial incentives also exist because hearing officers have no job tenure and other terms and conditions of employment are left up to each carrier. As a consequence, Part B hearing officers are tempted to please their insurance company employers to avoid retaliation. This problem of pecuniary interest can only be heightened by the fact that the carrier has no appeal from the hearing officer's decision. Thus, if the carrier disagrees with a decision, does not want it to be adhered to by that hearing officer in future similar cases, and cannot persuade the hearing officer to reverse himself, the carrier has essentially no choice but to terminate the hearing officer. Given the extreme situation presented, the district court was clearly correct in holding that "Part B hearing officers have a pecuniary interest in currying the carrier's favor." J.S. 10a.

The Secretary argues that because the amounts of Medicare claims paid by the carriers are reimbursed by the government, the carriers have no financial incentives to deny claims, and therefore there is no bias based on pecuniary interest. HHS Br. 30. This argument improperly attempts to shift the focus away from the tribunal itself, the individual hearing officer. The pecuniary interest of that individual hearing officer is different from that of the carrier. The hearing officer's financial interest is in continuing to be called to conduct hearings, which depends on his pleasing the carrier employee who supervises him. Thus, for that hearing officer, the relative size of the hearing system and the program as a whole is irrelevant. *Cf.* HHS Br. 31. The hearing officer's job security is what is at stake.

However, if Part B hearing officers perceive that carriers want them to be fiscally conservative, they are almost certainly correct, for, as was explained above, it is in the interest of these insurance companies to restrict payments of claims to Medicare beneficiaries. Although theoretically a carrier could be admonished for not paying a meritorious claim, there is no evidence in the record that this has ever happened.

The Secretary also argues that the district court failed to find, and the Medicare beneficiaries failed to prove, a pattern of actual bias in individual Part B hearing officers. HHS Br. 30, 35. However, the relevant inquiry is not into the number of instances of actual bias that can be demonstrated, but as to whether possible temptation is presented. *Tumey v. State of Ohio, supra*, 273 U.S. 510, 532 (1927), *In re Murchison, supra*, 349 U.S. 133, 136 (1955). The

Part B hearing system fails to meet the impartiality requirement of due process because, when all of its undisputed circumstances and relationships are considered, there exists a possible temptation for hearing officers to curry the favor of the carrier.

Another way of stating the constitutional standard is in terms of the appearance of bias. This Court has repeatedly affirmed the principle that, " 'justice must not only be done but must manifestly be seen to be done . . . .' (citation omitted)." *Joint Anti-Fascist Refugee Committee v. McGrath*, 341 U.S. 123, 172 n.19 (1950). The Part B hearing system clearly presents an appearance of bias, not only to the court below but to the informed public. The American Bar Association House of Delegates, with members who are familiar with the daily workings of the Part B system, has stated that "it is unreasonable to expect the [Part B] hearing officer to be impartial." The National Commission on Social Security, charged by Congress to review the Medicare Part B program has concluded that a hearing officer's "impartiality could be compromised because of association with the carrier." *See* pp. 16-17 *supra*. Thus it is clear that the Part B hearing system does not comport with traditional notions of fundamental fairness.

III

THE PART B HEARING SYSTEM VIOLATES DUE PROCESS BY VESTING FINAL DECISION-MAKING AUTHORITY OVER MEDICARE CLAIMS IN INSURANCE COMPANY HEARING OFFICERS

The second basis for the district court's holding was that due process requirements are violated by the vesting of

final decision-making authority over Medicare Part B claims in carrier-appointed hearing officers. It is important to note at the outset that the district court did not take issue with Congress' decision to delegate the $10 billion Medicare Part B program administration to private insurance carriers. Rather, the court treated solely the far narrower matter of the absence of a right of appeal from Part B hearing officer decisions, and held that "[o]nly by vesting final decision-making authority in an independent tribunal will Part B beneficiaries' due process rights be adequately protected." J.S. 16a. The district court's conclusion is clearly correct.

This Court has stated that:

> [A] purpose of procedural due process is to convey to the individual a feeling that the government has dealt with him fairly, as well as to minimize the risk of mistaken deprivations of protected interests.

Carey v. Piphus, 435 U.S. 247, 262 (1978). Part B procedures fail to meet this test.

The notion of fair treatment by the government implies the right to a "meaningful opportunity to be heard." *Little v. Streater*, 452 U.S. 1 (1981). Medicare beneficiaries do not receive a meaningful opportunity to be heard since the Secretary has abdicated his responsibility to hear appeals to private insurance companies. *See Fuentes v. Shevin*, 407 U.S. 67, 93 (1972).

The district court holding is in agreement with the decisions of other courts which have dealt with reimbursement disputes under the Medicare Act. Indeed, a number of courts have held that delegating governmental adjudica-

tory functions to private entities meets due process standards only if the claimant can appeal to the delegating administrative agency or to the courts.

In *St. Louis University v. Blue Cross Hospital Service*, 537 F.2d 283 (8th Cir. 1976), *cert. denied*, 429 U.S. 977 (1976), the Eighth Circuit considered this issue in the context of Part A of the Medicare program and the private committees that decide certain reimbursement disputes between "providers" (*i.e.*, hospitals and nursing homes) and the insurance companies that administer the Part A program. The circuit court interpreted the Medicare Act to require administrative review, noting that "due process precluded vesting the final determination of these issues in the Committee as constituted . . . ." *Id.* at 293.

In another case involving Medicare, the delegation of governmental judicial authority to a private entity was permitted only on clearly specified terms and conditions, including the right to further review of the private entity's decision. *Association of American Physicians & Surgeons v. Weinberger*, 395 F.Supp. 125 (N.D.Ill.), *aff'd*, 423 U.S. 975 (1975). There the district court upheld the delegation of governmental decision-making to private agencies, Professional Standards Review Organizations, because independent review of their decisions was available. *Id.* at 140.

These due process holdings refute the Secretary's unsupported claim (HHS Br. 33-34 n.29) that there is no difference for due process purposes between hearings conducted by private individuals employed by a private government contractor and hearings conducted by regular government

employees.[21] *See* p. 28 *supra*. Moreover, these principles are seen in sharp relief when considering that the Part B hearing system is unique in delegating governmental adjudicatory functions without a right to administrative or judicial review.

The Medicare beneficiaries submit that the case law on the constitutionality of delegation of government decision-making to private persons establishes a presumption that fundamental fairness requires administrative or judicial review. Presumptions regarding fundamental fairness carry great weight in an assessment of a due process question. *Lassiter v. Dept. of Social Services*, 101 S.Ct. 2153, 2159 (1981).

The district court analyzed this unique situation by applying the three part test in *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976) and held that due process required some form of review by the Secretary. J.S. 12a-15a.

The test set forth in *Mathews v. Eldridge*, requires an evaluation of three factors:

> [F]irst, the private interest that will be affected by the official action; second, the risk of an erroneous

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[21] *See Coral Gables Convalescent Home, Inc. v. Richardson*, 340 F.Supp. 646, 650 (S.D. Fla. 1972), holding that due process requires an independent review of a decision of a private insurance company administering Part A of Medicare concerning recoupment of an overpayment to a nursing home. *See* Homer and Platten, *Medicare Provider Reimbursement Disputes: An Analysis of the Administrative Hearing Procedures*, 63 GEO. L.J. 107 (1974). An extensive discussion of the constitutionality of delegation of adjudicatory decision-making to private parties, not limited to government health insurance programs, is found in Liebmann, *Delegation to Private Parties in American Constitutional Law*, 50 INDIANA L.J. 650, 702-04 (1975). *See also Dahlberg v. Pittsburgh & Lake Erie R.R.*, 138 F.2d 121, 123 (3rd Cir. 1943).

> deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

First, the court noted that the private interest at stake, a Medicare beneficiary's right to reimbursement, is sufficiently important to invoke the Due Process Clause, and that the denial of that right may impose considerable hardship. J.S. 13a.

It should be considered, in assessing the individual interest at stake, that it involves health benefits, and permanent, not temporary, taking of property interests. In *Gray Panthers v. Schweiker,* 652 F.2d 146 (D.C. Cir. 1981) the D.C. Circuit applied this three-part test in connection with the procedural due process rights of Medicare beneficiaries and found their interest in claims of even less than $100 to be significant. The instant case involves claims of more than $100, the minimum amount at issue in a Part B hearing, and thus necessarily affects a greater interest. As the Court of Appeals stated in *Gray Panthers:*

> Nor can we ignore in any evaluation of the "interest at stake" the significant percentage of Medicare claimants disadvantaged by disability, illness and poverty, a substantially higher figure than is true of the population at large. Indeed, it was because of the special coincidence of medical needs and financial problems among elderly people that the Medicare program was established in the first place. *See* S. Rep. No. 1230, 92d Cong., 2d Sess. 37 (1972). . . . [T]he elderly still have lower incomes and higher medical expenses than other seg-

> ments of the population (footnote omitted). Thus, though need is not an eligibility criteria for participation in Medicare, a disproportionately large percentage of elderly recipients hover near the poverty level. Nonreimbursed medical bills of up to $100 represent a substantial loss to them.

Id. at 166.

Indeed, since all Part B claims are covered by this hearing system, the amount at stake can vary from $100 to the physician's fees for major surgery. There are, moreover, occasions where similar claims assigned to providers are consolidated, with extremely large sums in dispute at an individual hearing.[22]

In assessing the private interest, it is also relevant that most private supplemental health insurance policies for the elderly base their coverage largely on Medicare determinations. These policies will refer to the Medicare-approved "reasonable charge" for a given service, as a ceiling for coverage. Typically, the supplemental policies will cover the Medicare co-insurance and deductible amounts, which are set by statute and which will not ordinarily be in dispute at a Part B hearing. However, the supplemental coverage will not pay the difference between what the carrier has determined to be a "reasonable charge" and the actual

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[22]The Secretary states that approximately 50% of the claims in the Medicare system are assigned to providers (HHS Br. 45-46 n.42), but fails to mention the far more relevant fact that only a small fraction of Part B hearings are on assigned claims. Katz Deposition, Defendants' Appendix 282-83, Docket No. 48. Mr. Katz also acknowledged that many of the assigned claims involved consolidation of similar claims, and the amount at issue would necessarily increase. *Id.* Part B providers with assigned claims can best justify the cost of attending hearings if they can aggregate similar claims.

charge, with the result that the beneficiary will have an uninsurable out-of-pocket loss when a Part B hearing is lost. Health Care Financing Administration, U.S. Department of Health and Human Services, *Guide to Health Insurance for People with Medicare* 7 (HCFA Pub. No. 03079, Jan. 1981).

It is also significant that Part B beneficiaries cannot purchase comparable coverage at a comparable price through private policies. *See* p. 3 *supra*.

The second factor in the *Eldridge* test involves consideration of the risk of erroneous deprivation of benefits and the value of additional procedures. The reversal rate statistics presented were not found by the district court to be probative on this issue, as these reversals were in part due to a massive number of initial computer coding errors rather than changes in substantive determinations.[23] The court also considered that any modifications whatever in

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[23]There was evidence that carriers sometimes hold hearings on claims in which the issue turns on an "obvious error, whether clerical or input into the computer." Sometimes these errors are caught at an earlier stage. However, fluctuation in carrier policy as to whether it was necessary to "open" a hearing file when such errors were located after reconsideration led to fluctuations in the reported reversal rates. Byrne deposition, Defendants' Appendix 74-78, Docket No. 48.

A study of beneficiary appeals performed by the Region I Medicare Bureau found a large number of errors at the initial determination level: "many denials were effected based on incorrect coding." J.A. 52-59. Since most claims for Medicare benefits are "coded" for handling through modern data processing equipment, coding errors mean a higher error rate in payment of claims. This high error rate in coding was confirmed in a study of "reasonable charge" reductions in Medicare Part B claims processing by Blue Cross-Blue Shield of New York. Report of the Comptroller General of the United States, *Reasonable Charge Reduc-*

favor of the claimant, even of an extremely small fraction of the disputed amount, were considered "reversals". J.S. 13a.[24] There was evidence in the record that the Secretary's own staff viewed the reversal rate statistics as distorted. J.A. 56.

There is a general problem in using statistics in a constitutional case involving fairness; the reversal rate of an "ideal" fair judge is unknown, because the precise error rate is unknown. There is thus no standard for interpreting the meaning of reversal rates. Such statistics, standing by themselves are unilluminating. *See Lassiter v. Dept. of Social Services,* 101 S.Ct. 2153, 2161 n.5 (1981). As this Court noted in *Mathews v. Eldridge,* "[b]are statistics rarely provide a satisfactory measure of the fairness of a decision-making process." 424 U.S. 319, 346 (1976).

Also of vital importance is that claimants' losses are permanent. Unlike *Mathews v. Eldridge,* where the question was one of the timing of the hearing and the deprivation of benefits was therefore only temporary, the instant case involves deprivation of benefits without any possibility of erroneous determinations being corrected later.

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tions and Related Matters Under Part B of Medicare, in *Medicare and Medicaid Guide* ¶ 27,475, at 10026, 10028-29 (CCH, 1975 Transfer Binder). The General Accounting Office of the Comptroller General concluded that "at least 16,000 or 13.0 percent, of the 123,500 line items, were incorrectly coded and resulted in erroneous reasonable charge reductions of at least $608,000."

[24]There was evidence in the record below that 93.9% of the "reversals" at Part B hearings conducted by Blue Shield of California between January 1, 1975 and June 30, 1980 were actually "partial" rather than complete reversals. These statistics are summarized in Appellees' Memorandum in Opposition to Application For Stay 5 n.6. No. A-961, October, 1980 term.

As has been demonstrated, the current hearing system is inadequate to protect against erroneous permanent deprivation of benefits. These privately employed hearing officers, acting with unreviewable authority, have not satisfied any threshold selection criteria such as knowledge of the law. The district court is clearly correct in finding that additional safeguards are needed.[25]

The third factor in the *Eldridge* test requires an assessment of the governmental interest. The Medicare beneficiaries submit that the governmental interest lies not only in controlling costs but also in issuing appeal decisions that are fair and perceived to be so by the public. One of the purposes of due process "is to convey to the individual a feeling that the government has dealt with him fairly." *Carey v. Piphus*, 435 U.S. 247, 262 (1978). The fact that the American Bar Association and the National Commission on Social Security have condemned the current Part B

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[25]It should be noted that the Secretary has made an incomplete delegation of power to Part B hearing officers. Thus, Medicare Part B hearing officers do not have the basic powers needed by a judicial officer. They do not have the power to subpoena documents needed to prove facts, the power to order witnesses to submit to depositions, or the power to administer the oath to witnesses. *Hearing Officers Handbook*, J.A. 49; *Carriers Manual* §§ 12017C, 12020D, J.A. 27, 35. Thus, Medicare claimants whose services were rendered by physicians or other suppliers of services who are unwilling to donate the time needed to prepare testimony or other evidence crucial to supporting their claims are simply unable to prove their cases because they have no way of compelling the production of evidence. Since "medical necessity" for the services is a key requirement for payment of claims, the unavailability of such evidence is often crucial. *See* Byrne deposition, Defendants' Appendix 54-55, Docket No. 48.

hearing system demonstrates that the system does not currently serve this governmental interest.

The Secretary acknowledges that the scale of the current hearing system, which entails determinations on about $16 million in disputed claims per year, is quite small compared to the massive $10 billion claims volume of the system as a whole. HHS Br. 31 n.28. To allow a further right to a hearing by the Secretary can only involve a small increment in the cost of the hearing system, since only a fraction of those who receive Part B hearing decisions can be expected to request further review.[26] Thus, the cost for assuring the integrity of Medicare Part B claims administration is modest.

Moreover, in reaching its initial conclusion that some review by the Secretary was needed, the district court noted that the cost of providing additional procedures will be minimized by the fact that the Secretary already has an existing procedure for governmental review of insurance company decisions under Part A of the Medicare program. Therefore, providing a further review of carrier hearing officer decisions "would not require the creation of a new appeals system or a new bureaucracy." J.S. 14a.

The district court's conclusion that due process requires that final decisions on Medicare Part B claims be made by a hearing officer independent of the carrier is thus amply

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[26]Not all persons who receive Part B hearing decisions would have a right to appeal under the district court's order, but only persons who receive unfavorable decisions with at least $100 remaining in controversy. According to the Secretary's statistics (HHS Br. 48 n.44), approximately 30% of the latter group seek review by the Secretary.

supported by a consideration of these three governing factors in the *Mathews v. Eldridge* analysis.[27]

The Secretary claims that Part B hearing officers are at least minimally competent to conduct hearings, and therefore the district court's view that a more competent body should conduct reviews is not of itself grounds to find a due process violation.

To the contrary, the record in this case shows that Part B hearing officers, as a group, are not minimally competent to reach final decisions on Medicare claims. These cases involve interpretation of complex laws and regulations.[28] The selection criteria prescribed by the *Carriers Manual* are so general that the qualifications of the hearing officers are, as a practical matter, left up to the carrier. Byrne deposition, Defendant's Appendix 15-16, Docket No. 48. *See* pp. 22-23 *supra*. In the case of Defendant Blue Shield

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[27]It is the Secretary's position that the district court erred in applying the *Eldridge* "balancing process" because in his view, that process could only be undertaken *after* a finding that the carrier hearing officers are not "minimally competent" to conduct Part B hearings, and because, in the Secretary's view, the record does not support such a finding. HHS Br. 43-44. Since the *Eldridge* test itself addresses the risk of erroneous deprivation, which might entail an assessment of the qualifications of the hearing officers, the Secretary seems to be arguing that the same issue be considered twice, once before applying the *Eldridge* test at all, and once as part of the *Eldridge* test. There is simply no authority, or basis in logic, for this approach to an assessment of due process requirements.

[28]*See Carriers Manuel*, 12-12 to 12-12.1, Attachment A to Affidavit of Stanley Katz, Exhibit B to Defendants' Memorandum in Support of Motion for Summary Judgment, filed November 20, 1979, Docket No. 37.

of California, the most common qualification of the hearing officers selected, as the Secretary acknowledges (HHS Br. 42 n. 37), was a long association with the carrier. This would seem to be a hindrance to independent review of claims rather than a qualification. It is also notable that HHS' Health Care Financing Administration takes the position that extensive training of Part B hearing officers is not needed (Katz deposition, Defendants' Appendix 281, Docket No. 48), and leaves most of the training up to the carriers who hire the hearing officer. J.S. 11a. Additionally, these insurance companies only conduct hearings on Medicare cases, and thus have developed no expertise in providing hearings in any other context. *See* p. 25 *supra*.

IV

THE DISTRICT COURT ORDERED APPROPRIATE RELIEF

On May 5, 1981, the district court entered its final judgment providing that persons dissatisfied with Medicare Part B decisions issued by carrier appointees have a right to a *de novo* hearing before an ALJ of the Social Security Administration. J.S. 34a-37a. This decision was based on submission of proposed plans by the parties pursuant to the court's order of July 9, 1980, extensive briefing, and argument. J.S. 22a; *see* J.A. 6-10, Docket Nos. 67-108.

The court ordered the simplest and most equitable relief possible. There already exists a corps of ALJs within the Social Security Administration, which hears beneficiary appeals under Part A of the Medicare Act as well as Title II, 42 U.S.C. § 401, and Title XVI, 42 U.S.C. § 1381, of the Social Security Act. In connection with their current duties,

ALJs are well qualified to consider medicolegal matters, and are experienced and trained in conducting hearings. They have knowledge of issues which arise under both Parts A and B of the Medicare program, and there are instances where they may be deciding the precise issues under Part A that carrier hearing officers are called upon to consider under Part B. Moreover, ALJs are tenured, experienced attorneys with fixed salaries, are independent of the carriers, and thus, are free from any taint of bias. *See Richardson v. Perales, supra,* 402 U.S. 389, 410 (1971).[29]

The district court's order creates no new bureaucracy. Further, it does not require any change in the internal workings of the carrier appeals system but simply adds a layer of appeal. It provides for a uniformity of decision-making in the Medicare program, in that the ALJ system can now consider common issues that arise in the Part A and Part B components of a given claim.

Further, the district court ordered that ALJs conduct *de novo* reviews of Part B claims, as they do on other claims within their jurisdiction pursuant to existing regulations. 20 C.F.R. § 404.946, § 404.953. By providing for *de novo* review the district court insured that any findings of the Part B hearing officers could be set aside. *See Goss v. Lopez,* 419 U.S. 565, 581 n.10 (1975) where this Court

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[29]At the time of the *Perales* decision, the hearing personnel in the Social Security Administration were designated as "hearing examiners," rather than their current title "Administrative Law Judges."

stated that judicial review which is not *de novo* could not cure administrative irregularities.[39]

The Secretary argues for the first time on appeal that appropriate relief, if any, based on the record in this case "would have been for the court to order HHS to take measures to improve the qualifications of the hearing officers that the *carriers* appoint. . . ." HHS Br. 43, 13.

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[39]In *Erika, Inc. v. United States*, 634 F.2d 580 (Ct. Cl. 1980), *cert. granted*, 101 S.Ct. 2312 (1981), the Court of Claims held that it had jurisdiction to review "constitutional and statutory challenges to benefit determinations under Part B of Medicare." *Id.* at 587-88. The "amount of a particular benefit determination—as, for example, a carrier's determination that $50 rather than $100 a physician charged was a reasonable amount for services," *id.* at 588, was held to be outside the Court of Claims jurisdiction and thus unreviewable by it. The Medicare beneficiaries do not question the merits of the *Erika* decision. Indeed, we submit that the result in *Erika* is irrelevant to determination of the instant case. For even if limited judicial review is allowed in the Court of Claims, Part B beneficiaries are still entitled to an impartial decision maker in the administrative process.

In a wide variety of situations, this Court has consistently stated that the existence of some form of judicial review does not obviate the necessity for "an adequate administrative procedure" in the first instance. *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 21 (1978) and cases cited at 20 n.26; *see also Ward v. Village of Monroeville*, 409 U.S. 57, 61-62 (1972). The reasoning in these cases is compelling here. First, should this Court affirm in *United States v. Erika, Inc.*, No. 80-1594, judicial review is limited to constitutional and statutory challenges. Thus, many aggrieved Medicare beneficiaries would remain without any remedy. Second, the expense of litigating in the Court of Claims renders it, as a practical matter, inaccessible to most Part B claimants. Third, *de novo* review is unavailable in the Court of Claims. Thus, the tainted findings of Part B hearing officers cannot be altered by the Court of Claims. Only by providing claimants with an unbiased administrative forum will due process be satisfied.

The Secretary's proposed relief would not cure the essential problem of bias in the current system. The hearing officers would still serve at the will of the carriers.

In the proceedings below, the Secretary advocated that the appropriate relief was to create a new hearing system to be staffed by attorneys who were currently assistants to ALJs, rather than by ALJs.[21]

The district court declined to authorize a new bureaucracy and hearing corps to provide hearings only on Part B claims. Its order was clearly correct, inasmuch as a new bureaucracy, created by court order, could entail extensive judicial supervision. Unlike the existing ALJ system, which handles Part A and other Social Security Act cases, a new corps would be a non-statutory establishment totally foreign to the Medicare system. This Court has rejected creation of plans totally alien to a statutory scheme in the formulation of constitutional relief. *Califano v. Westcott*, 443 U.S. 76, 92 (1979).

The basis for the Secretary's opposition to the relief ordered is, in part, a claim that providing ALJ hearings

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[21]The Secretary's current disagreement with the use of ALJ hearings, which appears to be focused on their credentials as experienced attorneys, is thus inconsistent with his position below. *Compare* HHS Br. 8-9 n.6 *with* HHS Br. 42. Moreover, this case bears no resemblance to cases in which this Court has held that non-lawyers may conduct administrative hearings, because here no review by a legally-trained appellate tribunal is available to protect against misapplication of the law. *See, e.g., Parham v. J.R.*, 442 U.S. 584, 616 n.22 (1979). *See also North v. Russell*, 427 U.S. 328, 339 (1976), where this Court held the right to a *de novo* hearing by a lawyer-judge to be determinative in finding that a non-lawyer police court system met due process guarantees.

for review of Part B decisions would lead to "substantial cost and disruption to the Medicare program and other programs administered by HHS. . . ." HHS Br. 47-48. This is a serious misstatement of the likely effect of the district court's order. The Secretary acknowledges that approximately 30% of those who received notices of a right to an ALJ review of their Part B decisions have requested such a review.[32] Of the 16,511 persons who received adverse Part B decisions in 1980, not all would be eligible to request ALJ reviews. HHS Br. 48 n.44. Thus, 30% of 16,511, or 4,953, is probably an overestimate of the annual number of Part B reviews. In contrast, the ALJ system within the Social Security Administration had a 1981 workload of 281,737 hearings. HHS Br. 49 n.48. Thus, the district court's order would lead to an increment of less than 2% of the workload of the ALJ system. The Secretary has never claimed that the Social Security Administration could not hire enough ALJs to accommodate this 2% increase in hearings. Moreover, the Secretary has not presented any cost analysis to show that creation of a whole new bureaucracy to handle Part B reviews is more cost effective than simply hiring more ALJs.[33]

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[32]HHS Br. 48 n.44. Of approximately 8,000 persons who have received notices pursuant to the judgment below, 2,313 have requested ALJ hearings.

[33]The Medicare beneficiaries proposed to the district court another plan, which would have ALJs replace Part B hearing officers. Proposed Order Approving Plan for Implementation of Judgment, received October 17, 1980, Docket No. 84. Since there was evidence in the record that the cost of ALJ hearings and Part B hearings were closely comparable, this relief might also have involved little if any additional cost. Affidavit of David Lowell George, November 26, 1979, Plaintiffs' Appendix 209-12, Docket No. 38.

The Secretary's disagreement with the trial court's remedy thus presents the narrow issue of whether that court properly exercised its broad discretion by ordering a simple appeal process rather than establishing a new and unique federal hearing system.

CONCLUSION

For the above-stated reasons, the decision below should be affirmed.

January, 1982

Respectfully submitted,

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Office - Supreme Court, U.S.
FILED
FEB 22 1982
ALEXANDER L. STEVAS
CLERK

No. 81-212

In the Supreme Court of the United States

OCTOBER TERM, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

WILLIAM MCCLURE, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

REPLY BRIEF FOR THE APPELLANT

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Appellees challenge the constitutionality of a provision in an Act of Congress under which scores of thousands of hearings on individual medical reimbursement claims have been held since Part B of the Medicare program was enacted in 1965. They have offered no evidence based on the experience of the last 16 years that the hearing process does not operate fairly, in the manner that Congress and the Secretary have prescribed. Instead, they rely on unsupported speculation that carrier-appointed hearing officers might not be impartial and reliable decision-makers. Such speculation cannot form the basis for holding an Act of Congress unconstitutional. The congressional plan deserves far greater deference, and appellees and the Court should "not presume on this record to say that it works unfairly" (*Richardson* v. *Perales*, 402 U.S. 389, 403 (1971)).

1.a. Appellees argue (Br. 31-34) that carrier-designated hearing officers cannot be regarded as impartial because they have a pecuniary interest in the decisions they make. Yet appellees concede (Br. 32, 33) that neither the hearing officer nor the carrier that appoints him has a financial interest in the award or denial of benefits in a particular case, since the hearing officer's own salary and any claims he finds to be meritorious are paid out of the federal treasury. This absence of a financial interest in the decision-maker and the entity with which he is affiliated renders the cases upon which appellees rely wholly inapposite. See *Connally* v. *Georgia*, 429 U.S. 245 (1977); *Gibson* v. *Berryhill*, 411 U.S. 564, 578-579 (1973); *Ward* v. *Village of Monroeville*, 409 U.S. 57 (1972); *Tumey* v. *Ohio*, 273 U.S. 510 (1927); see also *Marshall* v. *Jerrico, Inc.*, 446 U.S. 238, 250-251 (1980).

Appellees argue, however, that hearing officers retained by carriers as independent contractors[1] do not have job tenure or a guaranteed annual income and that they therefore have a "possible temptation" to "curry the favor of the carrier" (Br. 34) by denying claims in order to preserve their job security and stable income. The fundamental flaw in this argument is that it necessarily rests on the premise that a *carrier* has a financial incentive to deny meritorious claims, such that the hearing officer would perceive that he could further the carrier's interest and thereby gain its favor by doing likewise. As just explained, however, a carrier has no such financial interest in the determination of individual claims because the expense of paying them is borne entirely by the federal treasury.

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[1] As explained in our opening brief (at 29 n.26), the hearing officers of the only two carriers about which there is evidence in the record all were independent contractors, although we understand that in other instances carrier employees may be designated as hearing officers.

b. Appellees nevertheless assert that "it is in the interest of these insurance companies to restrict payments of claims to Medicare beneficiaries" (Br. 33), apparently because, in appellees' view, "HHS has built into its system for administering the Medicare program a number of cost-saving devices which instill in the private carriers a sense of the importance of conserving Medicare program money" (*id.* at 17; see generally *id.* at 17-21). This assertion is without merit. Under 42 U.S.C. 1395u(a)(1)(A) and (B), the Secretary is to enter into contracts under which the carrier must "make determinations of the rates and amounts of payments required pursuant to [Part B]" and "disburse * * * funds in making such payments." The Secretary would violate this statutory duty if he sought to induce carriers to decline to make an award that is required by the Act, and there is no substantiation in the record for appellees' suggestion that he has done so.

Appellees place principal reliance on measures undertaken by the Secretary to maintain the integrity of the program or to control the cost of its administration, as distinguished from the amount paid out to beneficiaries in reimbursement for covered services. The "PARE" (Payment Review) program discussed by appellees (Br. 17-18), for example, grew out of measures first adopted in 1968 and 1969 to protect the integrity of the program by identifying physicians or other furnishers of Part B services who may innocently or fraudulently permit overutilization of covered services. It was not instituted to induce carriers to deny meritorious claims, as appellees intimate. Under the PARE program, claims for services performed by those physicians identified with a pattern of overutilization (as compared with other physicians in the area) are specially reviewed when they are first submitted to the carrier to ensure that the services were medically necessary.[2] See *United States* v. *Sanet*, No. 81-

[2] See Appendix to Defendants' Reply to Plaintiffs' Memorandum of Points and Authorities in Support of Motion for Summary Judg-

5192 (11th Cir. Feb. 1, 1982), slip op. 323. Measures such as this are undertaken pursuant to authorization in the Medicare Act for the Secretary's contracts with carriers to provide for the carriers to assist persons who furnish services to beneficiaries in "the development of procedures relating to utilization practices" and to "assist in the application of safeguards against unnecessary utilization." 42 U.S.C. 1395u(a)(2)(B). This initial screening has no effect on the hearing officer's consideration of the claim at a later stage.

Surely the Secretary would not be thought to have introduced an element of bias into a benefit program that was administered by HHS itself simply by establishing an internal screening procedure to identify possible fraud or abuse in the expenditure of some $10 billion in public funds annually. There likewise is no reason to conclude on the present record that the requirement that carriers adopt similar internal checks has introduced an inherent bias into the carrier hearing process.

Appellees also assert that "a significant portion of Medicare administrative costs is spent on reducing amounts paid to beneficiaries, because of the expense of 'controlling overutilization' and reducing 'reasonable charges'" (Br. 18). In support of this broad assertion, however, appellees cite only a single statement of administrative costs for one carrier—Blue Cross and Blue Shield of Greater New York—for one year, 1976. This financial statement simply indicates that some $1,312,063 were spent for a budget item entitled "[u]tilization and reasonable charge review," which appellees characterize as reflecting "attempts to reduce the amount paid as benefits" (Br. 18). Appellees seriously mischaracterize the record in citing this isolated and unexplained budget item as evidence of a program-wide effort to limit proper bene-

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ment, at 81-85, 254-255 (hereinafter "Defendants' Appendix"); Appendices to Plaintiffs' Memorandum of Points and Authorities in Support of Motion for Summary Judgement, at 201-203 (hereinafter Plaintiffs' Appendices).

fit payments. The record does not disclose how those particular funds were spent. Moreover, the budget caption says nothing about "reducing amounts paid to beneficiaries," "reducing" reasonable charge levels, or discouraging utilization of covered services, as appellees imply. To the contrary, the caption suggests the wholly proper goal of protecting against overutilization or abuse and ensuring the accuracy of reasonable charges for a broad range of covered services. The amount allocated, $1.3 million, hardly seems excessive for this purpose in a major metropolitan area, and the total expended on this budget item constituted less than 6% of the carrier's overall administrative expenses for the year. We simply fail to see how appellees can attach any significance to this figure.

All that remains in support of appellees' suggestion that carriers have an interest in restricting the total amount paid in reimbursement of Part B claims is their generalized assertion that "[w]arnings about controlling overutilization of services dominate the instructional material given to providers and the annual reviews of carriers' performance (ACERs)" (Br. 18). However, appellees do not cite even one item of such "instructional material" to support this assertion, and they rely only a single six-page excerpt from one Annual Contractor Evaluation Report (ACER), that for Occidental Life Insurance Company of California for the year 1976.[3] That excerpt is entitled "Carrier Management" and is concerned principally with the carrier's overall administrative efficiency and accuracy in processing claims. Less than two pages of the excerpt are devoted to a discussion of the carrier's efforts to control program integrity and quality, addressing such things as fraud detection and accuracy in claims processing, to the end that "claims adjudication is accomplished in accordance with the provisions of the Social Security Act, health

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[3] The excerpts upon which appellees rely are reproduced in Plaintiffs' Appendices, *supra*, note 2, at 191-196.

insurance regulations, and general instructions."[4] These obviously are entirely appropriate measures to ensure the proper expenditure of public funds. There are only passing references to overutilization. Contrary to appellees' assertion, then, the theme they portray hardly "dominates" even the single document upon which they rely.

c. In sum, there is no support whatever in the record for appellees' repeated assertions that the Secretary has imposed requirements that the carriers reduce the overall amount paid out in reimbursement for covered claims.[5] Accordingly, there is no support for appellees' speculation that carriers have an incentive to reduce such payments—and, in the process, to deny otherwise meritorious claims—in order to satisfy such a requirement and thereby to ensure that their contracts with the Secretary remain in effect. To the contrary, the Act and the Secretary's contracts with the carriers require the carriers to determine correctly the amount of payments required to be made under the Act for covered services, and to make those payments. 42 U.S.C. (& Supp. III) 1395u(a)(1)(A) and (B), 1395u(b)(3); 42 C.F.R. 421.200; see also 42 C.F.R. 405.803(a) and (b). The Secretary may terminate the contract with a carrier if he finds that the carrier is not performing these obligations as required. 42 U.S.C. 1395u(b)(4); 42 C.F.R. 421.205(a). Thus, in order to ensure compliance with the contract and avoid possible termination, it would be in the interest of the carrier—and in the interest of hearing officers seeking to maintain the

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[4] Plaintiffs' Appendices, *supra*, note 2, at 193; see *id.* at 192-194.

[5] Appellees also cite measures undertaken by the Secretary to reduce the carriers' *administrative* costs, including experimentation with competitive bidding rather than fixed-cost contracts with entities selected to act as the Secretary's agents in paying Part B claims (Br. 18-20). These measures do not have the purpose or effect of reducing the overall amount paid to beneficiaries, and they therefore would not have any tendency to induce carriers to deny payment of meritorious claims.

favor of the carrier—to ensure that hearings are scrupulously fair and that benefits are paid when the Act and implementing regulations and instructions so require.[6]

d. Appellees' suggestion (Br. 21-26, 32-33) that a hearing officer might ignore his obligation to be independent and impartial and instead rule against a beneficiary in order to curry the carrier's favor also is wholly unsubstantiated. Appellees assert (Br. 32), for example, that if a carrier requests a hearing officer to reopen a decision in favor of a beneficiary but the hearing officer declines to reverse his decision, "the carrier has essentially no choice but to terminate the hearing officer." Yet appellees cite no instance in which a hearing officer's contract with a carrier has been terminated, much less an instance in which such a termination occurred because of dissatisfaction with the hearing officer's decision in a particular case or even in a series of cases. Nor is there any testimony in the record by any hearing officer that he has ever experienced such pressure, subtle or overt.

2. Appellees also argue (Br. 27-30) that the "prior involvement" of the hearing officer in the claims he reviews creates an unconstitutional bias in the hearing process. Appellees concede (Br. 28), as of course they must, that the hearing officers have not actually had any *personal* involvement in cases that come before them, which would violate HHS regulations and instructions. 42 C.F.R. 405.824; Carrier's Manual § 12016(B), J.A. 22. Appellees contend, however, that a situation in which a hearing officer reviews a previous decision of his

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[6] Appellees acknowledge that "a carrier could be admonished for not paying a meritorious claim" (Br. 33), but assert (*ibid.*) that there is no evidence in the record that this has ever happened. Appellees are incorrect. There are several instances documented in the record in which HHS has requested that a hearing be reopened because it appeared, after HHS's sample review, that meritorious claims were denied. See Defendants' Appendix, *supra*, note 2, at 363-364, 368. See generally *id.* at 363-396.

employer (the carrier) "may pose" a risk of bias of a similar nature. As we have explained in our opening brief (at 32-34), however, the Due Process Clause is not violated if one employee of an administrative agency holds a hearing on a matter in which another employee of that agency previously has participated. See, *e.g.*, *Morrissey* v. *Brewer*, 408 U.S. 471, 485-486 (1972); *Goldberg* v. *Kelly*, 397 U.S. 254, 271 (1970). There is no reason why the result should be any different in the case of employees or independent contractors affiliated with a carrier under Part B of the Medicare program, who, like employees and hearing officers in HHS, serve as agents of the Secretary in administering a particular title of the Social Security Act. See Appellant's Br. 15-16, 19-20, 33; see *e.g.*, 42 C.F.R. 405.860.

Appellees attempt (Br. 28) to distinguish the two situations on the ground that government employees have job tenure but carrier hearing officers do not and that the latter therefore are not entitled to the "presumption of honesty and integrity" that this Court has held to be due those serving as adjudicators. *Withrow* v. *Larkin*, 421 U.S. 35, 47 (1975). The record does not indicate that the factual distinction based on tenure is as clear as appellees suggest. Hearing officers retained by a carrier pursuant to a contract might well have a cause of action for breach of contract if the relationship were improperly terminated by the carrier, and the Secretary would regard a retaliatory termination as a matter of serious concern in the carrier's administration of the Part B program. See Appellant's Br. 29-30 & n.27. For these reasons, and because the carrier has no financial incentive to terminate a hearing officer because of rulings in favor of beneficiaries, appellees' concern about arbitrary dismissals seems rather unrealistic. See Appellants' Br. 29-30. In any event, appellees have pointed to no authority, and we are aware of none, for the novel proposition that the Due Process Clause implicitly man-

dates a civil-service-like system of job tenure or protection for persons serving as adjudicators.[7]

Finally, appellees rely (Br. 16) on a report prepared by the Committee on Health Law of the American Bar Association and the report of the National Commission on Social Security in contending that Part B hearing officers are not impartial decision-makers. See ABA Amicus Br. 7a; *Social Security in America's Future, Final Report of the National Commission on Social Security* 278 (Mar. 1981). Neither report, however, furnishes any documentation for their respective statements that Part B hearings are not "truly fair" or that the imparti-

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[7] Appellees also attack the integrity of Part B hearing officers on the grounds that (i) the Secretary has not established detailed qualifications for the position or imposed a uniform salary schedule or case load for hearing officers throughout the country and (ii) hearing officers receive training by the carriers. See Br. 22-25, 30. Contrary to appellees' assertion, however, these factors merely reflect the deference shown by Congress and the Secretary to the carriers' expertise and judgment in administering the Part B insurance program. There is no basis for concluding that this flexibility, which allows for experimentation with different approaches, introduces an element of bias into the carrier hearing system. The Secretary's monitoring of the carriers' performance serves to guard against such an eventuality. See Appellant's Br. 23-24.

Appellees argue (Br. 25) that this monitoring does not ensure hearing officer independence because critiques of hearings after HHS's sample review are sent to HHS regional offices, not the carriers. However, the record makes clear that the regional offices are to furnish the critiques to the carriers and that this approach is followed because it is the regional offices, rather than HHS headquarters, that monitor the carriers' performance on a day-to-day basis. Defendants' Appendix, *supra*, note 2, at 7-8, 112, 178, 266. Appellees also contend that the Occidental Insurance Company official responsible for Part B hearings never received any feedback from the Secretary regarding the conduct of Part B hearings. The witness's recollection was faulty, for the record in this case contains documentation of one such instance. *Id.* at 368-369. In any event, the absence of more extensive feedback, if indeed there was none, may reflect nothing more than that HHS's review of Occidental's hearings revealed that hearing officers were performing their duties properly.

ality of Part B hearing officers "could be compromised" by their affiliation with the carrier. The statements are, in short, conclusory assertions, apparently based on nothing more than inferences the two bodies have chosen to draw from the statutory framework of the Part B program. As such, they do not impeach the considered judgment of Congress and the Secretary to the contrary.

Moreover, neither report takes the position that Congress' provision for Part B hearings to be conducted by carriers is unconstitutional. The Resolution actually adopted by the ABA House of Delegates simply urges the appropriate committees of the Senate and House of Representatives to address the need for legislation (ABA Amicus Br. 1a), and the National Commission's report similarly is merely a recommendation for statutory change. In like fashion, if appellees believe that the statutory hearing procedure should be altered, the proper forum for consideration of their arguments is Congress.

3. Appellees offer little new in support of their independent argument (Br. 34-45) that the Due Process Clause prohibits the vesting of final decision-making authority in carrier-appointed hearing officers even if the current system of carrier hearings is found to be fair and impartial. We have fully addressed this issue at pages 39-50 of our opening brief, and we offer only a few additional observations.

a. Nowhere in their discussion of this issue do appellees acknowledge the specific basis on which the district court held the system of carrier-conducted hearings unconstitutional under the three-part due process test announced in *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976). The basis of this holding was not that the *procedures* followed in Part B hearings are inadequate to afford a meaningful opportunity to be heard.[8] The

[8] There is no support in the record for appellees' bald assertion (Br. 42 n.25) that crucial medical evidence is often unavailable because Part B hearing officers cannot compel the production of evidence. As explained at page 25 n.24 of our opening brief, moreover, the Secretary's subpoena power under 42 U.S.C. 405(d) could be exercised for this purpose. In any event, this issue is not involved here.

district court's holding turned entirely on the identity of the individual who presides at the hearing. In the court's view, the Due Process Clause requires Part B hearings to be conducted by the Secretary solely because Part B hearing officers appointed by the carriers receive what the court believed to be insufficient formal training by HHS and need not satisfy "specific" eligibility criteria, such as having a law degree. From this, and without explanation or reference to supporting evidence, the court simply "assumed that additional safeguards"—presumably meaning hearings by ALJs in HHS—"would reduce the risk of erroneous deprivation of Part B benefits" (J.S. App. 14a).[9]

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[9] Appellees argue (Br. 8-9; see also *id.* at 45-49) that the district court did not actually hold that the Due Process Clause requires that Part B hearings be conducted by ALJs in HHS, but rather simply held that the current system of carrier-conducted hearings violates the Due Process Clause and ordered that the hearings be conducted by ALJs in HHS in the exercise of its discretion to fashion appropriate relief. We disagree. A comparison of the training and qualifications of Part B hearing officers and ALJs who conduct Part A hearings was the basis for the court's conclusion that "additional safeguards" were needed in Part B hearings under the second prong of the *Mathews* v. *Eldridge* test. See J.S. App. 13a-14a & n.10 (citing Plaintiffs' Memorandum of Points and Authorities in Support of Motion for Summary Judgment, at 6-13, which compares the Part A and Part B programs). Under the third prong of the *Mathews* v. *Eldridge* test, moreover, the court discussed only the use of the Part A ALJ procedure in concluding that the additional cost to the government would not be substantial (J.S. App. 14a), and the two options the court observed were available to the Secretary to cure the perceived due process problem both entailed the use of ALJs (*id.* at 16a). See also *id.* at 22a.

The Secretary proposed a plan to implement the court's judgment that would have provided for attorney-advisors in the Social Security Administration's Office of Hearings and Appeals, rather than ALJs, to conduct Part B hearings, but this was rejected by the district court. Appellant's Br. 8-9 n.6. If appellees are correct that the district court did not actually hold that the Due Process Clause requires ALJ hearings, the court should have accepted the Secretary's plan. Appellees seek to defend the district court's rejection of the Secretary's plan on the ground that the court simply "declined to

As we explain in our opening brief (at 42), however, the Due Process Clause does not require that the person presiding at an administrative hearing be a lawyer, especially where the issue involved concerns medical matters for which training in medicine or experience in medical insurance would be a suitable background. See, *e.g.*, *Parham* v. *J.R.*, 442 U.S. 584, 607 (1979); *Morrissey* v. *Brewer*, 408 U.S. 471, 486, 489 (1972). Moreover, appellees do not point to any evidence in the record that Part B hearing officers in fact do not meet whatever qualification the Due Process Clause might impose for hearing officers. See Appellant's Br. 42-43. Without such a showing, the presence or absence of a formal program of training is irrelevant. There is every reason to believe, for example, that the experience of most hearing officers, together with their study of hearing procedures, would sufficiently qualify them for the job.

Nor have appellees sought to substantiate the district court's assumption that attorneys—even ALJs—in HHS would conduct significantly more reliable hearings. See Appellant's Br. 47.[10] Much less have they substantiated

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authorize a new bureaucracy and hearing corps to provide hearings only on Part B claims" (Br. 48). It is not, of course, for the courts to "authorize" or "decline to authorize" a particular organization of an Executive Department. The district court's proper role was limited to determining whether the Secretary's plan comported with due process requirements.

[10] Appellees contend (Br. 40-41) that the statistics showing that hearing officers reversed prior determinations in between 42% and 51% of the cases do not substantiate the fairness or accuracy of the current Part B hearing process because these figures include partial as well as total reversals. Because the majority of hearings raise reasonable charge issues (Appellants' Br. 47), it is not surprising that a hearing officer often might grant some but not all of the amount claimed in reimbursement. Moreover, because distinct claims may be aggregated in a single hearing, 42 C.F.R. 405.820(b)(2), a "partial reversal" could reflect a ruling for the beneficiary on one claim and a denial on another in the same hearing. The record indicates that the average award in all reversals, partial and total, averaged more than $200 from 1975 through 1978

this assumption with the clarity and weight of evidence that would be necessary to warrant this Court's holding unconstitutional the Act of Congress that explicitly rejects this very approach. Indeed, assuming that the district court was correct in its assessment of the qualifications of Part B hearing officers, the court could have remedied this problem without declaring an Act of Congress unconstitutional simply by ordering that *carrier* hearing officers possess whatever qualifications and receive whatever formal training the court believed was required by the Due Process Clause.

b. Appellees also suggest (Br. 15, 35-37 & n.21) that the Part B hearing process raises a possible problem of undue delegation of governmental power to a private body. Contrary to appellees' suggestion, however, this case raises none of the concerns about a "delegation" of power to "private parties" that have arisen in other contexts. The Act, its legislative history, and its implementation by the Secretary make clear that the carriers act as the Secretary's agents and perform their responsibilities subject to his supervision. As a result, the carriers, when performing their obligations under Part B, are not acting in the capacity of "private parties." Nor do the carriers or their hearing officers have a financial interest in the administration of the Part B program. Compare *Carter* v. *Carter Coal Co.*, 298 U.S. 238, 311 (1936); *Gibson* v. *Berryhill*, *supra*, 411 U.S. at 578-579; *Fuentes* v. *Shevin*, 407 U.S. 67, 93 (1972). And, finally,

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(J.A. 45)—hardly insignificant when compared to the amounts generally involved in a Part B hearing. At a minimum these data would appear to refute any suggestion of bias in the hearing process. *Richardson* v. *Perales*, *supra*, 402 U.S. at 410; Appellant's Br. 35-36 & n.31. Appellees attempt (Br. 40) to minimize the significance of these data by contending that some (unspecified) portion of the reversals are on "technical" grounds, such as where there has been an initial computer coding error. The prevalence of this ground is not demonstrated, however, and the particular ground for reversal does not in any event undermine the significance of a rate of reversal, partial or total, approaching 50%.

the performance by the carriers of their functions is subject to detailed substantive and procedural restraints imposed by Congress and the Secretary. Accordingly, this is not a situation in which Congress has delegated unfettered power without intelligible principles to guide its exercise or in which Congress has assigned to private parties the power to make social policy judgments or broad legislative or administrative decisions that should be reserved to Congress or to the Executive. See, *e.g.*, *Panama Refining Co.* v. *Ryan*, 293 U.S. 388, 430 (1935); *A.L.A. Schechter Poultry Corp.* v. *United States*, 295 U.S. 495, 537 (1935); *Industrial Union Department, AFL-CIO* v. *American Petroleum Institute*, 448 U.S. 607, 685-686 (1980) (Rehnquist, J., concurring in judgment); compare *Currin* v. *Wallace*, 306 U.S. 1, 15-16 (1939).[11]

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[11] The district court understood appellees' argument to be that 42 U.S.C. 1395u(b)(3)(C) constitutes an undue delegation of *judicial* power. See J.S. App. 2a, 4a, 8a. Such an argument plainly would be incorrect. By virtue of the United States' sovereign immunity to suit, appellees have no constitutional right to sue the United States in an Article III court to recover on a disputed claim under Part B of the Medicare Act. Congress' decision not to waive the United States' immunity to suit under Part B and to provide instead for an administrative adjudication of claims by carriers acting as agents of the Secretary therefore cannot be thought to constitute a prohibited "delegation" of Article III power. Cf. *McElrath* v. *United States*, 102 U.S. 426, 440 (1880). The presence of the sovereign immunity factor in this case and the corresponding absence of a pre-existing right at common law to sue the United States (see *Lehman* v. *Nakshian*, No. 80-242 (June 26, 1981), slip op. 4) also serve to distinguish the Railway Labor Adjustment Board cases discussed in Liebmann, *Delegation to Private Parties in American Constitutional Law*, 50 Ind. L. J. 650, 702-704 (1975), upon which appellees rely (Br. 37, n.21); those cases involved disputes between private parties, and even in that context the Court has not held that the vesting of exclusive jurisdiction in the Board is unconstitutional. See, *e.g.*, *Pennsylvania R. R.* v. *Day*, 360 U.S. 548 (1959); cf. *Andrews* v. *Louisville & Nashville R. R.*, 406 U.S. 320, 324-325 (1972).

For the foregoing reasons and the additional reasons given in our opening brief, it is respectfully submitted that the judgment of the district court should be reversed.

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FEBRUARY 1982

★ U. S. GOVERNMENT PRINTING OFFICE: 1982 387518 618

Amicus Brief

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Office - Supreme Court, U.S.
FILED
JAN 25 1982
ALEXANDER L. STEVAS,
CLERK

No. 81-212

In The
Supreme Court of the United States

OCTOBER TERM, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, *Appellant*

v.

WILLIAM MCCLURE, ET AL., *Appellees*

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

BRIEF OF THE AMERICAN BAR ASSOCIATION AMICUS CURIAE

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QUESTION PRESENTED BY AMICUS

Whether the claims appeal procedure of Part B of the Medicare Program, which rests final, unreviewable decisionmaking power in a hearing officer who is appointed by and serves at the will of the same private insurance carrier which has previously denied the claim violates the due process clause of the Fifth Amendment.

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

BRIEF OF THE AMERICAN BAR ASSOCIATION AMICUS CURIAE

INTEREST OF THE AMICUS CURIAE

The American Bar Association is a voluntary, national membership organization of the legal profession. Its more than 280,000 members come from every state, territory, and the District of Columbia. Since its inception over 100 years ago, the Association has taken an active role in the improvement of the administration of justice and the judicial and administrative process. In this regard, the Association has expressed a longstanding interest in maintaining the impartiality of administrative tribunals and ensuring that administrative hearings meet minimal due process standards.

As part of its activities to strengthen the legal system, the Association from time to time adopts recommendations propounded by Committees, Sections or Divisions of the Association calling for changes in the legal system. The recommendation on the administrative and judicial review of Medicare reimbursement controversies, reprinted as appendix A to this brief along with the underlying report, *infra*, reflects the Association's views on the principles of law presented in this *amicus curiae* brief. The recommendation was adopted as policy of the Association in August 1980, by its House of Delegates. The recommendation and the underlying report were prepared by the Committee on Health Law of the Young Lawyers Division of the Association.

Medicare benefits are of vital importance to elderly and disabled Americans. The Association's Committee on Health Law of the Young Lawyers Division and its Commission on Legal Problems of the Elderly have accorded special attention to the legal problems confronting the elderly and disabled, as well as health care providers, because of the inadequate and unfair claims appeal procedure under review in this case.

The Association, with the written consent of the parties,[1] respectfully sets forth its views herein on the important question of whether the claims appeal procedure of Part B of the Medicare Program violates the due process clause of the Fifth Amendment.

STATEMENT

The Medicare program, 42 U.S.C. § 1395 *et seq.* (Title XVIII of the Social Security Act, as amended), a health

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[1]Copies of letters indicating the parties' consent have been filed with the Clerk of the Court.

insurance program for the aged and disabled, consists of two basic components. Part A provides for certain hospital inpatient, extended care, and home health insurance benefits, which are funded out of social security taxes and paid from the Federal Hospital Insurance Trust Fund. Part B provides medical insurance benefits for certain medical services — primarily physician services — and is financed from premium payments by enrollees together with contributions from funds appropriated by the federal government and paid from the Federal Supplementary Medical Insurance Trust Fund.

Under Part B the Department of Health and Human Services (HHS) contracts with private insurance carriers to administer the program under broad guidelines issued by the Health Care Financing Administration of HHS. The carrier makes an initial determination whether, and to what extent, claimed benefits are reimbursable. 42 C.F.R. §§ 405.803-.806. Any claimant (or physician or other supplier who takes an assignment of the claim) who is dissatisfied with the initial determination may request a "review determination," which involves a *de novo* review of the written record by a carrier employee different than the one who rendered the intial determination. 42 C.F.R. §§ 405.801, 405.807-.812. If the amount in controversy is at least $100, a claimant (or assignee) who is dissatisfied with the review determination may request an oral evidentiary hearing. 42 U.S.C. § 1395u(b)(3)(c); 42 C.F.R. §§ 405.820-.835. The hearing officer, who is appointed by the carrier, may be, and often is, an employee of the carrier. 42 C.F.R. § 405.824. The hearing officer's decision is final; no further administrative or judicial review has been authorized by Congress or provided by HHS. 42 U.S.C. § 1395ff(b); 42 C.F.R. § 405.835.

In *McClure v. Harris*, 503 F. Supp. 409 (N.D. Cal. 1980), the court found the Part B appeal procedure violative of beneficiaries' due process rights. For the reasons set forth herein, the American Bar Association supports the decision of the district court and files this *amicus curiae* brief, respectfully submitting that the judgment below should be affirmed.

SUMMARY OF ARGUMENT

Medicare Part B beneficiaries are entitled as a matter of constitutional due process to a fair and impartial hearing with respect to claims denied by the Medicare program. The vesting of final, unreviewable decisionmaking power in a hearing officer who is appointed by and serves at the will of the private insurance carrier which has previously denied the claim raises serious questions about the adequacy of the Part B claims appeal procedure.

The American Bar Association agrees with the district court that the existing Part B appeal procedure does not afford Medicare beneficiaries minimal due process protections. Additional safeguards in the form of impartial tribunals are necessary.

ARGUMENT

I. The Right of Medicare Beneficiaries to Benefits Authorized by the Social Security Act Is a Property Interest Protected by the Constitution.

This Court and the lower courts consistently have held that the interest of Medicare beneficiaries in program benefits is a property interest to be afforded due process protection. *E.g., O'Bannon v. Town Court Nursing Center*, 447 U.S. 773, 780, 786 (1980); *Gray Panthers v. Schweiker*, 652 F.2d 146, 158 (D.C. Cir. 1981).

In the context of this case, there appears to be no dispute that Medicare Part B beneficiaries are entitled to due process protection and that protection entails some sort of hearing where beneficiaries' claims are denied. The inquiry, therefore, turns to whether the current Part B procedures are adequate to protect beneficiaries' due process rights.

II. Part B Hearing Officers Are Not Impartial Tribunals, In Contravention of the Due Process Clause.

In order to satisfy the principles of due process, a Medicare Part B beneficiary must be given a fair hearing. To meet this fair hearing requirement, the tribunal conducting the hearing must be impartial. *Withrow v. Larkin*, 421 U.S. 35 (1975); *Gibson v. Berryhill*, 411 U.S. 564 (1973).

As the district court found, the impartiality of Part B hearing officers "is compromised by virtue of both prior involvement and pecuniary interest." *McClure v. Harris*, 503 F. Supp. at 414. A hearing officer is engaged by the carrier which has twice denied the beneficiary's claim. The hearing officer's income is dependent upon the carrier's decision whether, and how often, to call upon the hearing officer. Further, in many cases, the hearing officer is a current or former employee of the carrier. Given these circumstances, the Part B hearing officer's impartiality must be questioned, and the Part B procedure must be found constitutionally inadequate.[2]

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[2]This Court has long been concerned with maintaining the appearance of impartiality of judges in any sort of tribunal. *Commonwealth Coatings Corp. v. Continental Cas. Co.*, 393 U.S. 145 (1968); *In re Murchison*, 349 U.S. 133 (1954). *See also* 28 U.S.C. § 455 and Canon 3C of the Code of Judicial Conduct.

III. The Vesting of Final Decisionmaking Authority in Carrier-Appointed Hearing Officers Violates Medicare Part B Beneficiaries' Due Process Rights.

The district court applied the balancing test of *Mathews v. Eldridge*, 424 U.S. 319 (1976), to determine that the vesting of final decisionmaking authority in Part B hearing officers is inadequate to protect beneficiaries' due process rights and that only by vesting final decisionmaking power in an independent tribunal will beneficiaries' due process rights be adequately protected. The court concluded that due process requirements would be protected by placing final decisionmaking authority for Part B claims in HHS administrative law judges who currently decide claims for beneficiaries under Part A of the Medicare program.

Under *Mathews v. Eldridge* a three-part balancing test is applied to determine what process is due in particular circumstances, weighing the following factors:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail. 424 U. S. at 335.

The district court applied that test below and determined: (1) the private interest of Medicare beneficiaries is worthy of due process protection and the denial of that right may impose considerable hardship, *cf. Gray Panthers v. Schweiker*, 652 F.2d at 166-167; (2) additional safeguards would reduce the risk of incorrect

deprivation of Part B benefits; and (3) the increase in claims being presented to HHS administrative law judges would not raise significantly the costs and administrative burdens of HHS.

The decision of the district court, reached after weighing the evidence presented by both parties, reflects a proper application of the *Mathews v. Eldridge* balancing test. The current Part B hearing procedure does not adequately protect beneficiaries' rights. Additional safeguards in the form of impartial tribunals for hearing Part B claims are necessary. The use of HHS administrative law judges to hear the Part B appeals provides a logical and ready method of providing beneficiaries a fair and impartial hearing.

IV. The American Bar Association and Others Studying the Medicare System Have Concluded that the Part B Hearing Procedure Is Unfair.

In August 1980, the House of Delegates of the American Bar Association adopted a recommendation calling for Congressional action to ensure meaningful and efficient administrative and judicial review of Medicare reimbursement controversies under Parts A and B. The recommendation and the underlying report recognize the fundamental unfairness of the Medicare Part B appeal process because of the potentially biased hearing officer:

> As a practical matter, under the current procedure there can be no truly "fair" hearing since the hearing officer is engaged by the carrier who rendered the initial adverse determination. Under these circumstances, it is unreasonable to expect the hearing officer to be impartial. Appendix A, p. 7a.

In the report, the Association also points to the lack of any opportunity for judicial review as underscoring the unfairness of Part B hearings. The Association therefore, in calling for Congressional action to remedy the situation, followed a very similar analysis as the district court did in concluding that the apparent lack of impartiality of hearing officers and lack of judicial review rendered the Part B appeal procedure unconstitutional.

In March 1981, the National Commission on Social Security, a bipartisan panel of private citizens charged by law to conduct a two-year review and investigation of all aspects of the Social Security System, submitted its report to the President of the United States and the United States Senate. The report considered the Part B appeal procedure and reached the same conclusion as the ABA and the district court:

> Initial determinations on [Part B] claims, reviews, and hearings are conducted by employees of the insurance carrier, and there is no judicial review.
>
> If the amount at issue in an entitlement claim is at least $100, a beneficiary dissatisfied with the carrier's award may request a hearing by an officer appointed by the carrier. Hearing officers may be disqualified upon a showing of prejudice, partiality, or interest in the matter. Although HCFA sets out very general selection criteria for these hearing officers, it does not review their qualifications. There is no nationwide uniformity in selection and training procedures.
>
> Final decisionmaking authority should not be given to an individual whose impartiality could be compromised because of association with the carrier whose decision is being appealed. The Commission recommends that hearings involving coverage of services under [Part B] be conducted by employees

of the Federal government, under rules to be established by the Secretary. National commission on Social Security, *Social Security in America's Future* 277-78 (1981).

The above reports are, of course, not binding on this Court. They represent, however, the considered judgment of knowledgeable and distinguished persons who have considered the very issue before this Court. The fact that they have reached the same conclusions as the district court regarding the potential partiality of carrier-appointed hearing officers and the inadequacy of Part B hearings is, we submit, entitled to substantial weight.

CONCLUSION

In view of the foregoing, the American Bar Association urges this Court to affirm the district court's holding that the claims appeal procedure of Part B of the Medicare program violates the due process clause of the Fifth Amendment.

Respectfully submitted,

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APPENDIX A

RECOMMENDATION

BE IT RESOLVED, That the House of Delegates of the American Bar Association urges the Health Subcommittee of the House Committee on Ways and Means and the Health Subcommittee of the Senate Finance Committee to address through public hearings the need for legislation to ensure meaningful and efficient administrative and judicial review of Medicare reimbursement controversies under Parts A and B of the Medicare program.

REPORT

A. Background

The Medicare program, 42 U.S.C. § 1395 *et seq.* (Title XVIII of the Social Security Act, as amended), a health insurance program for the aged and disabled, consists of two basic components. Part A provides for certain hospital inpatient, extended care, and home health insurance benefits, which are funded out of social security taxes and paid from the Federal Hospital Insurance Trust Fund. Part B provides medical insurance benefits for certain medical services — primarily physician services — and is financed from premium payments by enrollees together with contributions from funds appropriated by the federal government and paid from the Federal Supplementary Medical Insurance Trust Fund.

Under Part A, qualified hospitals, skilled nursing facilities, and other health care institutions, delineated "providers," are generally reimbursed directly by the Medicare program for 100% of the "reasonable costs" of services rendered to Medicare beneficiaries. Determinations of reasonable costs are generally made by commercial insurance companies and Blue Cross Plans,

known as "intermediaries," acting as fiscal agents of the Secretary of the Department of Health, Education and Welfare ("HEW").

When the Medicare program was established in 1965, Congress did not make any specific provision for judicial review of provider claims arising from challenges to intermediaries' determinations of reasonable costs. However, in the 1972 Amendments to the Social Security Act, Congress created the Provider Reimbursement Review Board ("PRRB"), an administrative board to be composed of five members from all spectrums of the health industry, to hear and decide reasonable cost disputes. Under the law, a decision of the PRRB is final unless within sixty days the Secretary of HEW reverses, modifies, or affirms the decision. Providers are entitled to judicial review in federal district court of PRRB decisions or of any action thereon by the Secretary if suit is filed within the time specified in the statute. 42 U.S.C. § 1395oo.

Under Part B, Medicare beneficiaries (or physicians who accept assignments of claims from their Medicare patients) are generally reimbursed by the Medicare program for 80% of the "reasonable charges" for covered medical services. Determinations of reasonable charges are made by commericial insurance companies and Blue Shield Plans, known as "carriers," acting as fiscal agents of the Secretary of HEW. The law requires carriers to establish procedures whereby Medicare beneficiaries are offered the opportunity for a "fair hearing" with respect to claims disputes involving amounts in controversy of $100 or more. 42 U.S.C. § 1395u(b)(3)(C). The right to a "fair hearing" has been extended by regulation to

physicians who accept assignments. 42 C.F.R. § 405.801. The hearing is conducted by a hearing officer appointed by the carrier. There is no provision in the law for administrative review of claims controversies under Part B, and 42 U.S.C. § 405(h) has been interpreted by the courts to preclude judicial review of such disputes.

B. Flaws in the Review Process

Current Medicare law and regulations have led in many cases to meaningless, time-consuming, and expensive administrative review of Medicare reimbursement controversies that cannot be resolved at the administrative level. Judicial interpretations of the statute have often closed the doors to meaningful judicial review, if any, of challenges by participants in the Medicare program to regulations and other policies of HEW, even after all available administrative appeals have been exhausted. Numerous controversies which can be resolved only by the courts have, in many jurisdictions, become hopelessly entangled in battles over the existence of subject matter jurisdiction. Consequently, claimants under Parts A and B have been forced to engage in forum shopping in an attempt to find a court that will decide the merits of their claims in a timely fashion, if at all; the resolution of Medicare reimbursement controversies on their merits has generally become a secondary consideration.

1. Part A Controversies

(a) *Current procedures require meaningless exhaustion of administrative appeals.* The first problem stems largely from the Secretary's regulation which binds the PRRB to comply with all regulations under the Medicare Act and to afford "great weight" to interpretive

rules and statements of policy of the Medicare Bureau, the component of HEW's Health Care Financing Administration which is directly responsible for the administration of the Medicare program. 42 C.F.R. § 405.1867. In those many instances in which a provider's claim is premised on a statutory or constitutional attack on the validity of a regulation, rule, or policy of HEW and its components, the PRRB is powerless to consider the arguments or to afford relief. Nonetheless, because of the statutory mandate for a PRRB hearing prior to judicial review, courts have strictly enforced the requirement for exhaustion of administrative appeals prior to allowing judicial review. *See, e.g., Association of American Medical Colleges v. Califano,* 569 F.2d 101 (D.C. Cir. 1977); *Humana of South Carolina, Inc. v. Califano,* 590 F.2d 1070 (D.C. Cir. 1978); *Rhode Island Hospital v. Califano,* 585 F.2d 1153 (1st Cir. 1978). Thus, providers must contend with needless delays and incur substantial expenses in presenting their arguments to an administrative forum which is impotent to provide the relief sought merely to meet the prerequisites for judicial review.

The futility of this procedure is well illustrated by the case of *Aristocrat South, Inc. v. Mathews,* 420 F. Supp. 23 (D.D.C. 1976), and the PRRB decision that followed. Aristocrat filed suit in federal district court challenging certain Medicare regulations on the ground that they were unconstitutional, arbitrary and capricious, and violative of the Medicare Act's reasonable cost provision. The court rejected Aristocrat's argument that, because the PRRB could not afford the relief sought, jurisdiction could be founded on 28 U.S.C. § 1331 (general federal question jurisdiction), and required Aristocrat to present its case to the PRRB. In its decision, PRRB Decision No. 76-D57, CCH Medicare and Medicaid Guide [1976

Transfer Binder] ¶28,108, at 10,406, the PRRB held, simply,

> although the Board is sympathetic with the provider's position, it must find for the intermediary as the Board is bound by the Regulations promulgated by the Secretary of Health, Education and Welfare.

Aristocrat was made needlessly to incur substantial delays and expenses in presenting its claim to the PRRB, and the PRRB was required to devote its limited resources to hearing and issuing a decision on the claim, all so that the PRRB could rule— as all knew that it must — that it was precluded from affording the relief requested by Aristocrat. The PRRB's decision is now being appealed to the federal district court for the District of Columbia (Civ. No. 76-2052), where the case was initially filed.

Thus, although Aristocrat first filed suit in 1976 challenging certain HEW regulations as unconstitutional and violative of the Medicare statute and the Administrative Procedure Act, it still has not been able to obtain a determination from any reviewing body on the merits of its arguments. It is obvious that, for both Aristocrat and the court, the PRRB proceeding was a worthless exercise which added nothing in the way of analysis or expertise to the resolution of the issues raised in the provider's challenge to the regulations.

The futility of the current procedure was also recently acknowledged by the Court of Appeals for the District of Columbia in *The Diplomat Lakewood, Inc. v. Califano*, Civ. No. 78-1852 (D.C. Cir. Nov. 16, 1979), another case where a provider contended that a regulation promulgated by the Secretary was arbitrary and capricious and failed to allow the reasonable cost of services. In the

course of holding for the provider, the Court of Appeals observed:

> [D]iplomat has already submitted its case to the PRRB pursuant to the district court's earlier instructions (420 F. Supp. at 27) and over Diplomat's protests — ultimately proven correct — that such a petition would be futile in view of the PRRB's limited jurisdiction;

At the same time, however, the Court of Appeals for the District of Columbia, as most other courts, has felt constrained by the statutory mandate for a PRRB decision to enforce strictly the exhaustion requirements even when the appeals procedure is indisputably futile.

The Committee on Health Law submits that Congress did not intend to require this wasteful commitment of resources. Rather, the Committee believes that Congress intended only to require resort to the PRRB when its expertise is pertinent to the claim and administrative resolution of the controversy is possible. The Committee urges Congress to hold hearings to consider this problem and to consider the need for legislation authorizing direct access by providers to the courts for the review of regulations and other administrative actions of HEW and its components. *Cf.* Consumer Product Safety Act, 15 U.S.C. § 2060 (1976); Fair Packaging and Labeling Act, 15 U.S.C. § 1455 (1976); Federal Food Drug and the Cosmetic Act, 21 U.S.C. § 371(f) (1976).

(b) *The administrative review process is unfair.* The administrative review process currently prescribed by statute is unfair in its authorization of review of PRRB decisions by the Secretary of HEW. Statistics compiled and issued by the PRRB for the four-year period from 1975 through 1978 illustrate convincingly that the review of PRRB decisions by the Secretary, through her delegate the Health Care Financing Administrator, has been

conducted in anything but an even-handed manner. During that period, the PRRB ruled upon 290 cases involving 465 issues. Of those issues, 36.4% were decided by the PRRB in favor of providers and 63.6% were decided against providers. Of those issues decided in favor of providers, 41.7% were reversed by the Secretary's delegate. Of those issues decided by the PRRB against the provider, the reversal rate was zero. While there may be some merit in the concept of review by the Secretary, as a practical matter it appears that HEW has abused this authority. Accordingly, the Committee on Health Law urges Congress to address the need for legislation to correct this flaw in the administrative review process.

2. Part B Controversies

The appeals process for claims disputes under Part B is even more inequitable and often leaves Medicare beneficiaries and physicians who accept assignments with no adequate remedy for injuries resulting from arbitrary and invalid actions by HEW.

The only review of adverse determinations by carriers regarding Part B claims that is prescribed under the Medicare Act is the so-called "fair hearing" required to be offered by carriers with respect to controversies involving amounts in dispute of $100 or more. 42 U.S.C. § 1395u(b)(3)(C). As a practical matter, under the current procedure there can be no truly "fair" hearing since the hearing officer is engaged by the carrier who rendered the initial adverse determination. Under these circumstances, it is unreasonable to expect the hearing officer to be impartial.

The discretion of hearing officers is also limited by a regulation similar to the regulation under Part A which

requires the PRRB to comply with regulations, interpretive rules and policy statements of HEW and its components. Hearing Officers are required to comply with regulations, policy statements, instructions, and other guides issued by the Health Care Financing Administration. 42 C.F.R. § 405.860.

The inequity resulting from current review procedures is illustrated by the current controversy involving Medicare reimbursement under Part B of charges for computerized axial tomography ("CAT") scans. *See Starnes v. Harris*, Civ. No. 79-2311-6 (D.S.C.) (filed Nov. 27, 1979). HEW established a reimbursement ceiling under Part B for CAT scans which is substantially lower than amounts previously allowed by carriers in making reasonable charge determinations. This ceiling was established through letters to carriers rather than through rulemaking. Carriers were instructed by HEW to implement the ceilings even though the Medicare law requires carriers, rather than HEW, to make reasonable charge determinations under Part B. The only available right of appeal of a carrier's application of HEW's ceiling under the statute is to a hearing officer appointed by the carrier. However, hearing officers are bound by regulation to comply with policy statements, instructions, and other guides of HEW and its components. Thus, hearing officers, like the carriers who engaged them, must adhere to HEW's ceiling regardless of whether charges higher than the ceiling amount are reasonable charges within the meaning of the law.

The inability of hearing officers to hear challenges to actions of HEW has generally left Part B claimants with no forum to challenge arbitrary and invalid administrative policies. The law does not provide for administrative

review of Part B claims. As indicated above, "fair hearings" under Part B are conducted by individuals engaged by carriers; there is no administrative tribunal comparable to the PRRB to which a Part B controversy may be appealed. Moreover, the law has been interpreted consistently by the courts to preclude judicial review of Part B claims. *See, e.g., Drennan v. Harris,* CCH Medicare and Medicaid Guide ¶ 30,060, Civ. No. 76-2766 (9th Cir. Sept. 4, 1979); *Pushkin v. Califano,* 600 F.2d 486 (5th Cir. 1979); *Cervoni v. Secretary of HEW,* 581 F.2d 1,010 (1st Cir. 1978); *Pritt v. Nationwide Insur. Co.,* 548 F.2d 1,129 (4th Cir. 1977); *Greenspan v. Blue Cross/Blue Shield of Greater New York,* 432 F. Supp. 1,339 (E.D.N.Y. 1977); *Simoncelli v. Weinberger,* 418 F. Supp. 87 (E.D. Pa. 1976); *Kuenstler v. Occidental Life Insur. Co.,* 292 F. Supp. 532 (C.D. Cal. 1968). *But see Waitley v. Califano,* CCH Medicare and Medicaid Guide ¶ 29,141, Civ. No. 77-2147 (D. Kan. 1978). *Cf. St. Louis University v. Blue Cross Hospital Serv.,* 537 F.2d 283 (8th Cir.), *cert. denied,* 429 U.S. 977 (1976).

The legislative history of the Medicare Act indicates that judicial review of Part B "claims" was not intended by Congress because it was felt that claims under Part B "will probably be for substantially smaller amounts than under Part A." S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 54-55, 1 *U.S. Code Cong. & Admin. News* 1,995 (1965). The assumption reflected by that statement has been shown to be erroneous in many circumstances. Individual claims of Medicare beneficiaries and physicians for reasonable charge reimbursement under Part B are generally less than institutional provider claims for cost reimbursement under Part A because provider claims generally involve costs of services rendered to many Medicare beneficiaries over a period of time. However,

aggregate claims of physicians and Medicare beneficiaries under Part B arising from a single invalid action of HEW affecting a single service covered under Part B may be great. For instance, HEW has made a conservative estimate that its reimbursement ceiling under Part B for CAT scans will result in a reduction in Medicare benefits of more than $8 million in fiscal 1979. A limited number of physicians and their Medicare patients will absorb the loss.

Furthermore, it is clear that Congress intended that Part B claimants be entitled to a "fair" hearing of their claims. Congress intended that such a hearing be provided through procedures established by carriers, but HEW's regulations have thwarted this objective in certain cases. Certainly, Congress did not intend that Part B claimants be denied access to any forum where a fair resolution of their claims could be obtained.

The problem is further aggravated by the decisions of several courts which have interpreted the statutory provision precluding judicial review of Part B "claims" (*i.e.*, 42 U.S.C. § 405(h)) also to preclude subject matter jurisdiction over matters not involving disputes as to claims for benefits but possibly having an indirect bearing, albeit remote, upon the amount of benefits allowed.

The dilemma confronting claimants under Part B is illustrated by the Fifth Circuit's recent decision in *Pushkin v. Califano*, 600 F.2d 486 (5th Cir. 1979). In *Pushkin* several licensed optometrists brought an action challenging the constitutionality of a provision of the Medicare law defining reimbursable services under Part B and the validity of a regulation promulgated thereunder, and seeking declaratory and injunctive relief. Even though the suit did not involve a claim for benefits,

the court determined that the challenge to the regulations could be recast to a claim for benefits and that the resolution of the constitutional challenge would determine whether or not benefits were to be awarded. Thus, the court held that it was precluded by 42 U.S.C. § 405(h) from taking subject matter jurisdiction over the case.

The Fifth Circuit recognized that the total preclusion of judicial review of the plaintiffs' statutory and constitutional claims would be constitutionally suspect, but, finding that the Court of Claims (unlike federal district courts) was not precluded by 42 U.S.C. § 405(h) from hearing such claims, concluded that judicial review was not totally precluded by its dismissal of the action. The problem, however, as recognized by the Fifth Circuit in its opinion, is that the Court of Claims is authorized only to grant monetary damages and could not grant the declaratory and injunctive relief sought by the plaintiffs. Thus, the Fifth Circuit's decision in effect closed the doors to the only effective relief for the plaintiffs, *i.e.*, an injunction against the enforcement of allegedly invalid regulations.

Decisions such as these, coupled with the regulatory limitations upon carrier-appointed hearing officers, result in Medicare beneficiaries and physicians being conclusively bound by actions of HEW, no matter how arbitrary and illegal those actions may be. The Committee on Health Law urges Congress to correct this glaring deficiency in the Part B program.

Amicus Brief

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No. 81-212

Office - Supreme Court, U.S.
FILED
JAN 27 1982
ALEXANDER L. STEVAS,
CLERK

Supreme Court of the United States

OCTOBER TERM, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

WILLIAM MCCLURE, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA

BRIEF AMICI CURIAE

of Coalition of Senior Citizens, Inc., Congress of Senior Adults, Living Is For the Elderly, Massachusetts Association of Older Americans, National Council of Senior Citizens, New York State-Wide Senior Action Council, Inc., Utah State Coalition of Senior Citizens and Western Gerontological Society.

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IN THE

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October Term, 1981

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RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

BRIEF AMICI CURIAE

OF

Coalition of Senior Citizens, Inc., Congress of Senior Adults, Living is For the Elderly, Massachusetts Association of Older Americans, National Council of Senior Citizens, New York StateWide Senior Action Council, Inc., Utah State Coalition of Senior Citizens, Western Gerontological Society.

INTEREST OF AMICI CURIAE

This brief is filed on behalf of eight non-profit organizations who have as their primary focus a concern for the quality of life of our elderly and disabled citizens.

The Coalition of Senior Citizens, Inc. is composed of forty-seven independent groups of older Americans in Hillsborough County, Florida. The Coalition advocates for the interests of its several thousand members in areas such as Medicare.

The Congress of Senior Adults is a non-profit organization of approximately 250 members in Jacksonville, Florida. It represents the interest of law and moderate income persons with a special emphasis on issues affecting elders such as Medicare.

Living Is For The Elderly (LIFE) is a non-profit organization of approximately 800 Massachusetts nursing home residents. The organization is active in efforts to improve the quality of life of nursing home residents.

The Massachusetts Association of Older Americans (MAOA) has approximately 18,000 members throughout Massachusetts. The organization provides direct assistance to elders on problems such as those involving Medicare Part B claims as well as advocacy on a national and local level on issues affecting older Americans.

The National Council of Senior Citizens has approximately three and a half million members organized in 3500 clubs throughout the United States.

Most of its members either currently participate in Medicare Part B or will soon be eligible to do so. The Council has a long history of effective advocacy concerning the rights of elderly persons on issues such as Medicare.

The New York StateWide Senior Action Council is a coalition of local senior citizen organizations which speaks for over three million elderly persons in New York. The Council is particularly concerned with issues affecting the aged poor such as the problems inherent in the present Medicare Part B adjudicatory system.

The Utah State Coalition of Senior Citizens was established in 1975 to assist senior citizens in their advocacy efforts. Its more than five thousand

individual members are vitally interested in assuring that their right to receive Medicare Part B benefits is not abridged by unfair procedures.

The Western Gerontological Society is a national organization of approximately 4000 practitioners, educators, policymakers, researchers, elders, business personnel and students who work with and for elders. Health care for elders is one of the two areas selected by its Board of Directors for special focus during the current year. Hence, the Society has a particular concern with respect to Medicare practices and procedures which present obstacles to the attainment of quality health care for elders.

These organizations share a conviction that Medicare Part B beneficiaries are entitled to an adjudication of their claims for benefits by an impartial governmental hearing officer who can evaluate their eligibility for specific benefits under the relevant statutory criteria. They recognize that the integrity of the entire Medicare Part B system is undermined when a private insurance company is given unrestrained power to finally determine the rights of Medicare Part B beneficiaries with no review of those determinations by any governmental entity.

Because of these organizations' long-standing work in advocating for the rights of older Americans, they believe their brief will be of substantial assistance to the Court in the resolution of issues raised by this case.

INTRODUCTION AND SUMMARY OF ARGUMENT

The district court has ruled unconstitutional the procedures provided under 42 U.S.C. §1395u(b)(3)(C) for the adjudication of claims for benefits under the government's program of Supplementary Medical Insurance for the Aged and Disabled (Medicare Part B). As the Medicare Part B program currently operates, all decisions concerning coverage of benefits are made by private insurance companies called "carriers". 42 U.S.C. §§1395ff and 1395u(b), 42 C.F.R. §421.3. There is no provision for independent review of the carriers' decisions by any governmental agency or the courts.

The district court found that the Due Process Clause of the Fifth Amendment to

the Unites States Constitution is violated by the combined effect of the following factors in the Medicare B adjudicatory system:

1) The hearing officers are appointed by the carriers who have previously denied the claim; and

2) The hearing officers have a pecuniary interest in the case since their income as hearing officers is dependent upon whether and how often the carriers choose to use their services; and

3) There are no specific selection criteria or training requirements for hearing officers; and

4) There is no provision for review of the carriers' decisions by any governmental agency.

Opinion J.S. App. 9a-11a and 15a-16a. Amici agree with the district court's ruling that the present system for adjudicatory claims under the Medicare

Part B program violates the Due Process Clause of the United States Constitution.

A.

The Medicare program of Supplementary Medical Insurance was initiated in response to a growing recognition that the health needs of our senior citizens were inadequately met. It was hoped that this governmental program would improve the health care of the elderly and thereby improve the quality of their lives. In contrast, adjudicatory procedures wherein eligibility for specific benefits under the Medicare Part B program is determined by private insurance companies called "carriers" present an obstacle for elderly and disabled persons who seek to exercise their right to receive Medicare Part B benefits. The "carriers" have unreviewable authority to determine

the eligibility of beneficiaries for services provided in a specific geographic area. The lack of review of the carriers' decisions by any governmental agency or the courts reinforces the beneficiaries' experience that geography rather than law may determine the outcome of a particular claim.

B.

The present Medicare Part B appeals system, by vesting final unreviewable judicial authority in a non-governmental private party, violates the principle of separation of powers which is an intrinsic part of our democratic system of government.

With the risk of administrative agencies having significant governmental power came a recognition of the need for

meaningful checks on the power exercised by those agencies. The Administrative Procedure Act (hereinafter "APA") was enacted to assure that administrative agencies would function in a manner consistent with the requirements of the Due Process Clause of the Fifth Amendment to the United States Constitution. The adjudicatory system of the Medicare Part B program deviates from the usual practice of governmental agencies in that Medicare Part B beneficiaries lack both the protections of an impartial hearing officer and judicial review afforded under the APA. As the present system now operates, the private insurance companies have a standing invitation to disregard the requirements of the Medicare statute and to exceed the powers conferred on them.

C.

The absence of any governmental forum in which Medicare B beneficiaries can contest the correctness of decisions made by private insurance companies creates an environment in which erroneous deprivations of Medicare Part B benefits can easily occur. The experiences of the three named plaintiffs in this action illustrate the seriousness of the problem as perceived by beneficiaries. Although the statute provides for uniform benefits throughout the country, wide variations in reimbursement decisions are commonplace. The failure to provide any mechanism for evaluating the Part B beneficiaries' claims in light of the Medicare statute, deprives them of statutory entitlements without due process of law.

D.

The right to receive Medicare Part B benefits is an important one for many elderly and disabled persons who would otherwise be without the means to obtain adequate health care. When Medicare Part B beneficiaries are unjustifiably denied benefits to which they are statutorily entitled without any hope of review by an impartial hearing officer, they become reluctant to again seek necessary medical care. The lack of any provision for governmental or judicial review of the private insurance companies' authority to make final non-reviewable determinations concerning eligibility for these statutory benefits results in serious harm to individual Medicare Part B beneficiaries and undermines the integrity of the entire system.

ARGUMENT

THE MEDICARE PART B STATUTORY SCHEME IN WHICH EMPLOYEES OF PRIVATE INSURANCE COMPANIES ARE GIVEN THE AUTHORITY TO MAKE FINAL NON-REVIEWABLE ADJUDICATIONS CONCERNING ENTITLEMENT TO GOVERNMENTAL BENEFITS VIOLATES THE DUE PROCESS CLAUSE OF THE FIFTH AMENDMENT TO THE UNITED STATE CONSTITUTION.

A. The Present Medicare B Adjudicatory Procedures Present a Significant Obstacle to Elderly and Disabled Beneficiaries In Their Attainment Of Statutory Rights.

The Medicare Program of Health Insurance for the Aged and Disabled codified

at 42 U.S.C. §1395 et seq. was developed in response to a growing recognition of the inadequate health care provided to our senior citizens. The Medicare Program consists of two parts: A Hospital Insurance Program referred to as "Part A" which covers in-patient and post-hospital care and a Supplemental Medical Insurance component referred to as "Part B" which covers, inter alia, physicians services, medical equipment and ambulance services. From the beneficiaries' point of view, the Part A Program is operated in a manner closely approximating the basic Social Security Program. While certain payment aspects under Part A are handled by insurance companies called "Fiscal intermediaries", 42 C.F.R. §421.3, the beneficiaries have a right to a hearing concerning their entitlement to specific benefits before an Administrative Law Judge of the Social Security Administration,

Office of Hearings and Appeals, 42 U.S.C. §1395u(b)(1)(C).

In contrast to the Part A Program, all review of the claimants' eligibility for Medicare Part B coverage is determined by the non-governmental private insurance company. Thus, Medicare Part B beneficiaries are placed in the position of paying monthly premiums (currently $11.00 per month) to the federal government's Social Security Administration, with no right to appeal an adverse decision concerning benefits to any governmental entity.[1/]

Under this system, the elderly and disabled are confronted with an undeci-

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[1/] Eligibility to participate in the Medicare Part B program is appealable in the same manner as eligibility for Medicare Part A and Social Security, 42 U.S.C. §1395ff(b)(1)(B).

pherable bureaucratic maze which even the young and healthy would find difficult to master. They are discouraged from attempting to penetrate the mystery of computer coded messages and bureaucratic jargon by the appearance of unfairness which envelopes the system as well as by their own reticence to assert their rights. See generally, Todd, Harry "Law Disputes and the Urban Elderly", University of California at San Francisco, Medical Anthropology Program (1980); and Nathanson, Paul and Berman, "Helping the Elderly Cope With Legal Conflict and Alternative Dispute Resolution", Report of Program in the Economics and Politics of Aging (Brandeis University, 1980).

These problems are graphically illustrated by information from the defendant's own studies which reveal that only 1.5% of the Medicare Part B

beneficiaries request a review of their denied claims. Since many of the denials are based on improper computer coding, approximately 50% of the claims reviewed are reversed. Beneficiary Appeals Study, J. App. at 53-55. Thus, it would appear that many Medicare Part B beneficiaries are improperly denied benefits because of failure to appeal an erroneous denial. While this failure to pursue administrative appeals may be due in some measure to the beneficiaries' lack of familiarity with complex bureaucratic structures[2/], the perception of unfairness generated by the absolute control of the system by private insurance companies is also a factor.

2/ See generally, Freedman, Crisis and legitimacy: The administrative process and American government, Cambridge University Press, Cambridge 116-124 and Alexander, G. "Foreword: Life, Liberty, and Property Rights for the Elderly", 17 Arizona Law Review 267 (1975).

Basic principles of the American democratic system are violated when private decisions are reinforced "by attaching governmental sanctions or acquiescence, while at the same time abdicating governmental control". Gellhorn, W. Federal Administrative Proceedings 144, (1941). The present Medicare Part B appeals system violates these principles by vesting in private parties the unreviewable authority to adjudicate the claims of beneficiaries.

Unless a system is developed whereby both the reality and appearance of fairness in determinations concerning benefit coverage is assured, the lofty purpose of the Medicare Program will be thwarted. Medicare Part B beneficiaries will continue to view the system as unfair and will continue to be deprived of their statutory rights.

B. The Medicare Part B Adjudicatory Procedures Provide No Check On The Exercise of Power By Private Parties And Ignore The Fundamental Rights Of The Medicare B Beneficiaries To A Fair Evaluation Of Their Claims For Governmental Benefits.

The system of checks and balances built into our constitutional form of government has long been viewed as an important restraint on the abuse of power by governmental officials. The present Medicare Part B adjudicatory system violates this basic doctrine of separation of powers in its most extreme manner by delegating not only administrative executive functions but final judicial authority to a private non-governmental entity. As a result of this system, many elderly and disabled

persons are deprived of important medical care and services by the unrestrained actions of private insurance companies called carriers. 42 C.F.R. §421.3. Medicare B beneficiaries in their relations with the carriers experience the coercive characteristics of a bureaucracy which are described by Freedman in Crisis and Legitimacy in the Administrative Process, 27 Stanford Law Review 1041, 1067 (1975):

> The traditional conception of the client whose individual needs supply the raison d'etre of an organization's efforts has become greatly attenuated as the process of bureaucratization has gone forward. Many employees of bureaucracies no longer regard themselves as serving clients at all, even though the stated mission of their organizational endeavors has not changed; ...The coercive structure of bureaucracy--by suppressing or ignoring individual distinctions in order to insure the efficient performance of its functions--has increasingly transformed an

> idealistic devotion to those in need of the organization's services and skills into patterns of behavior variously described as 'trained incapacity' (by Veblen) 'occupational psychosis' (by Dewey), and 'professional deformation' (by Warnotte).... Thus, those millions of persons who must deal regularly with bureaucracies, even when they do not find themselves confronted with 'the insolence of office', often regard the experience as frustrating and unpleasant nonetheless. [Footnotes omitted.]

The experiences of beneficiaries in dealing with the bureaucracy of the private insurance companies is reflected in the belief of the National Council of Senior Citizens

> that Medicare carriers are often more concerned with cost savings than with beneficiary services.

D. Ryan, "Medicare - A Consumer's Viewpoint", Perspectives on Medicaid and Medicare Management, Department of Health and Human Services, Health Care Financing Administration (hereinafter "HCFA") (February, 1981). These characteristics and perceptions of the Medicare B system become more crucial to the health of the elderly and disabled when the non-reviewability of the bureaucratic carriers' decisions is considered.

The safety value of an administrative appeals procedure under the Administrative Procedure Act, 5 U.S.C. §550, et seq. (hereinafter "APA") and subsequent judicial review provides a meaningful check on the bureaucratic characteristics of most governmental programs. In contrast, the Medicare B appeals procedure is devoid of any procedures designed to

save the beneficiaries from the unmitigated power of an autocratic bureaucracy.[3/]

An examination of the literature of administrative law prior to the enactment of the APA illustrates the problem faced today by elderly and disabled Medicare beneficiaries. In commenting on the problem, Roscoe Pound noted:

> In a constitutional legal policy all exercise of the power of politically organized society calls for checks. That checks are peculiarly needed with respect to administrative adjudication is made clear by consideration of certain tendencies ...

such as:

> 1) Failing to adequately "hear the other side";

3/ See, Myers v. United States, 272 U.S. 52, 293 (1926) (Brandeis, J. dissenting), and Youngstown Sheet & Tube Co. v. Sawyer, 343 U.S. 579, 593 (1952) (Frankfurter, J., concurring).

2) Making "determinations on the basis of consultations had in private or of reports not divulged";

3) Making "determinations injuriously affecting individual rights without a basis in evidence of rational probative force"; and

4) Setting up and giving "effect to policies beyond or even at variance with the statutes or the general law governing the action of the administrative agency".

R. Pound, Administrative Law, 67-73 (1942). The presence of these tendencies in the Medicare B adjudicatory system is illustrated by the experiences of the named plaintiffs discussed infra at 33-38.

The unfairness of the present Medicare B hearing system is illustrated by a comparison between the significant checks upon judicial power found to be

of special importance in a fair adjudicatory system and the present Medicare B appeals system. An important characteristic of the judicial system is the assurance that:

> Every judgment of a single judge is subject to review by a bench of judges, independent of the one whose action is to be scrutinized and constrained by no hierarchical organization or esprit de corps to uphold whatever he does.

Id. at 61.

The most serious violation of due process in the present Medicare Part B system is the lack of review of the hearing officer's individual decisions by any governmental agency or the courts.[4/]

4/ While a small percentage of decisions are apparently reviewed by HCFA in their evaluation of the carriers' overall performance, such "spot checks" do not conform to any traditional notions of appellate review.

The importance of such independent review is critical to assure that elderly and disabled persons (whose ability to assert their right to Medicare benefits may be severely impeded by the illness or injury for which they are being treated) will not be erroneously deprived of statutory benefits. Unreviewability gives the private insurance companies

> a standing invitation to disregard the statutory requirements and to exceed the powers conferred.

B. Schwartz, Administrative Law, §147 at 439 (1976). The absence of review subjects the carriers to no restraint except the self-restraint which is "foreign to the concept of division of the powers of government". Fleming v. Moberly Milk Products Co., 160 F.2d 259, 265 (D.C. Cir. 1947), cert. dismissed, 331 U.S. 786 (1947).

The reasoning concerning the retention of Civil Service Administrative Law Judges for Social Security hearings found in J. Mashaw "Report to the Grants and Benefits Committee on the Social Security Hearings and Appeals Process", Administrative Conference of the United States at 89 (1978) is instructive in the present context:

> The argument for retaining the administrative law judge in Social Security hearings is quite straight forward. The administrative law judge is, and can be seen to be, impartial. ... A less clearly independent corps of deciders would have greater difficulty resisting the institutional imperatives to reduce both the effort expended on individual cases and the number of awards.

The public perception of the unfairness of the present Medicare B adjudicatory system is illustrated by the

response of the persons affected by the District Court's order in the present case. Although plaintiff's counsel anticipated that relatively few beneficiaries would seek further review of the hearing officer's decisions, Motion to Affirm at 4-5, over twenty-five percent of the claimants who received adverse hearing decisions requested Administrative Law Judge hearings. Brief for Appellant at 48 n. 44. This number is significant when the factors militating against further efforts by ill, elderly and disabled persons to assert their rights are considered. These factors include physical handicaps such as visual or hearing impairments, the complexity of the reimbursement regulations and lack of access to the information on which the hearing decision may be based.

Numerous Supreme Court cases have recognized the paramount importance of fair adjudicatory procedure embodied in the constitutional system of checks and balances:

> Procedural fairness and regularity are of the indispensible essence of liberty.

Shaughnessy v. United States ex rel Mezei, 345 U.S. 206, 224 (1953), Joint Anti-Fascist Refugee Committee v. McGrath, 341 U.S. 123 (1951) and McNabb v. United States, 318 U.S. 332 (1943). Congress, which is itself subject to the checks and balances of the Constitution, has in its adoption of the Medicare B appeals system created a subordinate non-governmental body free from those constraints. The Court's reasoning in Ralpho v. Bell, 569 F.2d 607, (D.C. Cir. 1977) is particularly relevant to the present case.

The Medicare B adjudicatory system is analogous to the appeal system used for adjudication of certain claims of Micronesian residents at issue in Ralpho v. Bell. In Ralpho, the court was faced with a procedure for settling claims resulting from destruction of private property in World War II. Settlements were to be made by a governmental Commission whose decisions were to be

> final and conclusive for all purposes, notwithstanding any other provision of law to the contrary and not subject to review.

Id. at 613. The circuit court held that the federal court had jurisdiction to hear Ralpho's claims noting that it:

> beggers the imagination to suggest that judicial review might be less crucial to assuring the integrity of administrative action than it is to make

> certain that Congress will operate within its proper sphere.

Id. at 620. In the present case, final adjudicatory power is not even vested in a governmental agency such as the Micronesian Claims Commission but rather in a private insurance company.

The elderly and disabled have discovered that the private insurance companies tend to ignore their total medical condition and the individualized care needed for appropriate treatment. They resent the federal government's attempt to abdicate all responsibility for assuring that Medicare B benefits will be provided in accordance with statutory requirements.

Medicare Part B beneficiaries perceive the injustice of the adjudicatory system which denies them a fair

evaluation of their claim for necessary medical care and treatment and provides no check on the allocation of governmental benefits by private insurance companies.

C. There Is Presently No Forum In Which The Correctness Of Decisions Made By The Private Insurance Companies Can Be Evaluated By The Governmental Agency Charged With Responsibility For Administration Of The Medicare B Program.

As the present carrier-controlled system now operates, all decisions concerning eligibility for specific benefits are made by the private insurance company and its designees. There is no forum in which those decisions can be evaluated in the light of the Medicare

statute by any governmental or judicial body.[5/] The experience of the three named plaintiffs in this litigation graphically demonstrates the problem experienced by many elderly and disabled persons deprived of Medicare B benefits under the present system.

Plaintiff McClure was admitted to a small hospital in rural southern Humbolt County California. After making the diagnosis of Unstable Angina (Prinzmentals Syndrome), his attending physician consulted with specialists in San Francisco and determined that Mr. McClure was a candidate for immediate surgical intervention. The closest

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5/ It is not clear that the HCFA "spot checks" referred to at note supra, perform this function. Indeed the evidence in the court below suggests that HCFA only considers whether HCFA internal policy has been complied with. Appendix G to plaintiff's Brief in Support of Motion for Summary Judgment at 162-163.

hospital which could provide such emergency cardiac surgical services was located in San Francisco. Arrangements were made to transport him by an air ambulance equipped with trained personnel and the sophisticated medical equipment needed to assure his safe transport. In flight, Mr. McClure suffered a serious myocardial infarction which he survived due to the prompt intervention of the physician and nurse on board. Upon arrival at the hospital, the contemplated surgery was not performed due to the change in his condition.

The carrier's hearing officer, relying on an American Hospital Association list determined that a closer hospital had the capability to care for "cardiac patients" and thereby denied reimbursement for the air ambulance transport. This decision

was made despite uncontroverted evidence that the closer hospital did not have the capability to provide the emergency cardiac surgery which the claimant was expected to require. The hearing officer apparently interpreted Medicare requirements so as to place the burden of proof on the elderly claimant "to demonstrate that the [closer] hospital was not equipped to handle the case". Exhibit E to Complaint, p. 1. It is unclear how the elderly claimant was to meet this burden of proof other than by the uncontroverted testimony of his attending physician, Dr. Phelps, who stated:

> St. Joseph's Hospital does not have this capability [for the possible need for surgical intervention on an emergency basis].

Despite this definite statement, and the absence of any evidence that St. Joseph's Hospital could provide the sophis-

ticated surgery which was anticipated, the hearing officer found "nothing in the record" to demonstrate that St. Joseph's was not equipped to handle the case. Thus, although the Medicare statute, 42 U.S.C., §1395, provides for Medicare B coverage of ambulance service which is reasonable and medically necessary for treatment of an illness such as the life-threatening cardiac condition experienced by Mr. McClure, payment was denied.[6/]

The experience of plaintiff Shields similarly points up the problems inherent in the present system. Mr. Shields was denied Medicare coverage of an appendectomy on the basis of the private insurance

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6/ Reimbursement was authorized in an amount determined to be reasonable for the cost of ground ambulance service to a closer hospital which did not have the capacity to perform emergency cardiac surgery.

company's "guideline" treating all appendectomies as "incidental" to other abdominal surgery. In this circumstance, if Plaintiff Shields had a regular Blue Shield policy, he would be able to sue the insurance company to obtain a determination concerning the correctness of this decision. As a Medicare B beneficiary, however, Mr. Shields is precluded from having any governmental body or the courts review the correctness of the hearing officer's decision to apply the policy of Blue Shield to the government's Medicare B beneficiaries.

Likewise, plaintiff Doe was denied coverage of the Part B benefits associated with her hospitalization for a neocolporrhaphy. The hearing officer's decision was made despite a determination by an Administrative Law Judge of the Social Security Administration who ruled that

hospitalization for the surgery was covered under Part A of the Medicare Program. This disparity of decisions concerning coverage of treatment for the same medical conditions by the same patient at the same time is a common occurrence. Without the procedural safeguards of an impartial hearing by an independent government employee, the Part B adjudicatory system will continue to produce such stark discrepancies.

The effect of the non-governmental appeals system has a significant impact on the medical costs borne by our elderly and disabled citizens and is reflected in the Secretary's own studies. A report of "Physicians' Charges Under Medicare: Assignment Rates and Beneficiary Liability" Health Care Financing Review, 49, 63, (Winter, 1980), concluded:

> The payments for which the [Medicare B] beneficiaries were liable was very high relative to Medicare's Part A program--where beneficiary liability was less than 10 percent of hospital charges in 1975.

Another study of "Factors Affecting Differences in Medicare Reimbursements for Physicians' Services", Health Care Financing Review, 15 (Spring 1980), reported that under

> Medicare's Part B program, wide variations are found in average reimbursements for physicians' services by demographic and geographic characteristics of the beneficiaries.

Thus, although the Medicare program is designed to operate throughout the nation with a uniform set of benefits and a uniform set of cost-sharing requirements, the study supports the conclusion that geography rather than law may control the outcome of a particular claim. This study did not explicitly consider the effect of

the carrier-controlled adjudicatory system on the geographic disparity in benefit determinations. Nonetheless, the absence of nationwide governmental control of Medicare Part B claims may well be an important factor in the lack of uniformity identified by the studies.

The present Medicare B system, wherein the final adjudication of entitlement to governmental benefits is irrevocably vested in private parties, undermines the integrity of the Medicare B appeals system and ultimately the entire Medicare B Program. As the Court of Claims found in reviewing Medicare provider disputes, judicial review is necessary

> at least for compliance with the Constitution and the governing statute [Cites omitted].

Whitecliff, Inc. v. United States, 536 F.2d 347 (Ct. of Claims 1976). The absence of any

view by the government or the courts is perceived by Medicare beneficiaries as a serious violation of their constitutional rights.

D. The Present Medicare B Appeals System Unconstitutionally Deprives Beneficiaries Of Important Statutory Rights.

The right to receive Medicare B benefits is as important to elderly and disabled persons as the welfare and Social Security benefits found deserving of constitutional protection in Goldberg v. Kelly, 397 U.S. 254 (1970) and Califano v. Yamasaki, 442 U.S. 682 (1979). Although eligibility for Medicare benefits is not dependent upon financial criteria, the interest at stake, possibly life itself

as in the case of plaintiff McClure, cannot be minimized. The Medicare program was enacted in response to public recognition of the serious unmet health needs of our senior citizens identified by the White House Conference on Aging in 1961.

Amici believe that the characterization by the Secretary of the Medicare B program as a "voluntary program of supplementary medical insurance" which the beneficiary can "opt out of" and purchase a comparable private insurance plan (Brief for the Appellant at 46) is misleading. While, in theory, enrollment in the Medicare Part B program is "voluntary" (in the sense that potential beneficiaries can choose whether or not to participate) as a practical matter, there is no comparable private insurance plan which would enroll the high-risk elderly and disabled persons

who participate in Medicare.[7] The use of the term "supplementary" may also be misleading.[8] While Medicare B is titled "Supplementary Medical Insurance", it is in fact a program which provides

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[7] Most private insurance plans exclude at least for a time pre-existing medical conditions. There is no such exclusion in the Medicare B program. The charges for private insurance are greatly in excess of the amounts charged by the government. Currently, Medicare B beneficiaries pay a premium of $11.00 per month whereas the actuarially adequate rate is approximately $16.30 for aged persons and $25.50 for the disabled. Report of the National Commission on Social Security, n.3 at 261 (March, 1981).

[8] The lower court appears to have been thus misled in stating that "Part B covers supplementary rather than primary services". Opinion J.S. App. at 13a. Physicians services comprised 71 per cent of the Part B payments made during fiscal year 1979. Medicare Annual Report, 2 Fiscal Year 1979, HHS, HCFA. Physicians' services are clearly basic health services without which provision of most other medical care is improbable if not illegal.

basic health care benefits including physicians' services such as expensive and life-saving cardiac and neurological surgery, out-patient services, durable medical equipment and a variety of similar services. These services are often as necessary for the health of the recipient as the in-patient care provided under the Health Insurance Program referred to as Medicare Part A.

Furthermore, while in theory, the carrier's decision on an issue of coverage of a specific Medicare claim does not preclude receipt of benefits in other circumstances, financially strapped elderly and disabled claimants are often reluctant to seek necessary medical care in the face of uncertain Medicare coverage. "Once burned, twice shy" is an axiom familiar to Medicare beneficiaries.

The present Medicare Part B Appeals system operates to deprive elderly and disabled beneficiaries of important health care benefits. The failure to provide any governmental or judicial check on the private insurance companies who make final non-reviewable determinations concerning eligibility for these statutory benefits results in serious harm to individual Medicare beneficiaries and undermines the integrity of the entire system.

CONCLUSION

Amici agree with the National Commission on Social Security that the Secretary should be required to adopt procedures whereby hearings for coverage of services would be conducted by employees of the Federal government pursuant to promulgated rules. Report of the

National Committee on Social Security 278 (March 1981).

The order of the district court providing for review of Medicare Part B decisions by an impartial Administrative Law Judge should be affirmed.

Respectfully submitted,

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